Childhood Trauma and Attachment Disorder: A Literature Review

by

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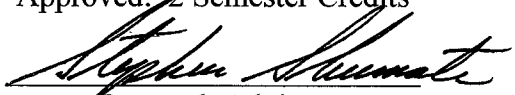

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ABSTRACT

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Bonding between parent and child is a reciprocal process that fosters human attachment. In turn, attachment affects a child's ability to form meaningful human relationships and to develop into a fully functioning adult. Impairment of bonding and attachment has devastating developmental implications for a child. Exposure to neglect, abuse, and violence result in serious deficiencies of physical, emotional, social, behavioral, and moral development. These traumas distort essential aspects of love and trust that have lasting impacts on self-esteem, human relationships, and psychological health. Several specific psychological disorders are associated with attachment problems caused by early childhood neglect and trauma, including Reactive Attachment Disorder.

Therapy that addresses the cognitive distortions of impaired attachment and the rebuilding or repair of human attachments can improve lives and prevent intergenerational transmission of negative parenting behaviors. This literature review examines the existing scholarly understanding of healthy and pathological attachment, and the specific problems caused by early childhood neglect and trauma. Promising treatment approaches for attachment-related disorders are discussed and recommendations for further theoretical and therapeutic progress are included.

Acknowledgments

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Chapter One: Introduction

Forming and maintaining relationships with others is a natural part of human development. People establish and maintain varying levels of relationships, ranging from intimate family relationships to mere acquaintances. One of the most important and critical relationships that one can experience is the relationship between parent and child. This significant relationship sets the tone for the rest of the child's life in terms of how the child develops physically, emotionally, socially, and morally. Strong, healthy bonding experiences between parent and child in the early critical years establish a secure attachment and a permanent connection that significantly impacts almost every facet of a child's development. While bonding is the set of behaviors that the parent and child reciprocally experience to and with each other, attachment is an instinctual human need that is fulfilled through these repeated and reinforced bonding behaviors (Levy & Orlans, 1998; Perry, 2000a).

Also referred to as a "mutual regulatory system" (Levy & Orlans, 1998), the attachment process and bonding experiences set the stage for nearly all areas of a child's development. A parent or caregiver's ability to successfully initiate, reciprocate and reinforce a loving, trusting relationship early in a child's life is critical for a child's ability to form attachments to others. A mutually supportive attachment process between a parent and child promotes security and trust that the parent will be available to provide a 'secure base' from which the child can independently explore the surroundings (Feinberg, n.d.). When not regularly soothed, comforted, and otherwise provided with emotional warmth during the first few years of life, a child can be at risk in many areas of

development, especially in affect regulation and the ability to form meaningful relationships (Cleveland, 2002).

The idea that infants and their parents or caregivers have a powerfully instinctual drive towards connectedness and attachment was not always supported. In the late 1920's, several schools of thought surfaced regarding optimal child development. Arnold Gesell, a prominent American pediatrician and researcher in child development, supported a strong genetic component to child development stating that children will develop regardless of how they are raised because the innate tendency towards the best possible development is very strong (Karen, 1998). Behaviorist John Watson claimed just the opposite, saying that children are products of their immediate environment and can be molded and shaped by others. Shockingly, Watson supported the idea that too much affection shown by the child's mother could be dangerous to a child, as the child would become too spoiled. An excerpt from his child-rearing book in 1928 advises:

> Treat them as though they were young adults. Dress them, bathe them with care and circumspection. Let your behavior always be objective and kindly firm. Never hug or kiss them, never let them sit on your lap. If you must, kiss them once on the forehead when they say goodnight. Shake hands with them in the morning. Give them a pat on the head if they have made an extraordinary good job on a difficult task (Watson, 1928; pp. 81-82, cited in Karen, 1998).

If this were the trend today, given what is known regarding the importance of nurturance and love early in life, children would be severely at risk for developing attachment difficulties, thus impeding their ability to form meaningful relationships. Fortunately, a third school of thought, represented by psychoanalyst John Bowlby,

advocated that while the instinctual drive to bond and form attachments is genetic, that there is a strong relational component as well between the mother and child. He asserted that an infant actively seeks out affectionate relationships with others, especially the first, critical relationship with the mother, and that this relationship sets the tone for all future relationships (Karen, 1998; Perry, 2000a). Bowlby (1969) contends that early deprivation can result in significant emotional, physical, and behavior difficulties.

In a perfect world, all children would be perfectly cared for, kept safe from harm, and provided the ideal environment from which to develop and maintain healthy, stable relationships. However, it is an unfortunate fact that sources of trauma such as physical and sexual abuse, neglect, community and domestic violence, loss, and frequent separations are quite common in today's world and that children are vulnerable. Every year, roughly 4 million children in the United States are at risk to such traumas as various forms of abuse and neglect, violence, natural disasters and significant injuries and accidents (Lowenthal, 1999). Physical abuse alone is the leading cause of death for children under one year old, and the numbers are increasing. From 1986 to 1993, there was a 100% increase in the number of children physically abused, bringing the number to 600,000 (National Center on Child Abuse and Neglect, 1993, cited in Levy & Orlans, 1998). Sexual abuse is a common precursor to developing an attachment disorder because it distorts what healthy, trusting relationships should represent. The most repeatedly reported and substantiated form of child maltreatment is neglect (Levy & Orlans, 1998). Of all the reports of child abuse, 65% of all cases involve some form of neglect such as physical, emotional, or medical. In addition, children are also vulnerable to both community and domestic violence, creating anxiety and fear in children early in

life. Witnessing violence also threatens children's sense of safety and security, putting them at risk for developing trusting, attached relationships with others (Monahon, 1993; Perry, 2000a). Finally, experiencing losses and separations early in life from primary caregivers creates feelings of insecurity and anxiety within children (Kagan, 2004). Many different areas of development can be impaired as children move around through different home placements.

When critical bonding experiences and attachment development are threatened because of trauma, the results are tragic for developing children. When trauma impedes children's abilities to form attachments with others, the stable base that provides security and safety is absent, leaving children to develop significant maladaptive defense mechanisms as a way to cope in the environment. The new set of behaviors and cognitive processes that children develop affect their ability to function in a socially acceptable way (Pickle, n.d.).

There seems to be a trend in research towards studying the devastating impact of trauma on children's abilities to form healthy, meaningful attachments to others. It is important that this area of child development continue to be studied because there continue to be many children at risk as well as many parents, teachers, counselors, social workers and foster parents who continue to be baffled by the multitude of behavioral, emotional, and cognitive difficulties that children with attachment disorders display. There are many treatment options tailored toward restoring and reestablishing attachments in children that were either destroyed or that had never existed. Both parent and counselor education is pertinent in deciding how to best help children learn to love and be loved.

Purpose of Study

The purpose of this study is to review and examine how traumatic events early in children's lives critically impact their development and specifically, how this detrimental influence in early childhood affect the ability to form healthy, secure attachments with others. This study will include normal development and attachment formation, several sources of childhood trauma, trauma effects on development and attachment, attachment disorders and treatment approaches. The purpose of this study will be accomplished through a literature review and critical analysis of the findings.

Research Questions

This study is directed by several research questions:

1. What role do parents and caregivers play in the development of both healthy and unhealthy attachment formation in children?
2. How does childhood trauma influence the ability to form meaningful attachments with others?
3. How do attachment disorders manifest and how can they be healed?
4. What are some treatment options for children with Reactive Attachment Disorder?
5. What are some implications for parents, caregivers and professionals in regards to recommending effective treatment interventions and additional research?

Definition of Terms

For purposes of this study, the following terms and concepts are defined:

1. *Trauma*: In this study, sources of trauma will include: physical and sexual abuse, neglect, violence, loss, and separation.

2. *Attachment*: "lasting, psychological connectedness between human beings…an unseen internal state in the parent and child" (Delaney, 1998, p. 3)
3. *Bonding*: "the process of forming attachment…involves a set of behaviors that will help lead to an emotional connection (attachment)" (Perry, 2000a, p. 6).
4. *Attunement*: "reading and responding to the cues of others; synchronous and interactive; helps prevent mismatch between need and provision" (Perry, 2000a, p. 6)

Limitations of the Study

This study is limited to a review of existing scholarly research of childhood trauma and attachment disorders. This study is examining research from published materials for the purposes of a comprehensive literature review and an analysis of the findings. The study relies on the integrity of existing scholarly work for information regarding childhood trauma and attachment disorders.

Chapter Two: Review of Literature

Introduction

This chapter provides a comprehensive review of literature regarding the role of childhood trauma in the development of an attachment disorder. This chapter will begin by briefly describing healthy childhood development. Throughout this chapter, childhood development will be examined from cognitive, social, behavioral, emotional, physical, neurological, and moral points of view. This chapter will then move into a discussion of attachment and the theory from which it is founded, as well as the early research from which attachment theory originated and developed. The healthy development and manifestation of attachment, as well as important precursors to the facilitation of attachment, is then reviewed. After the stage is set for how healthy attachment is developed and maintained, this chapter will examine childhood trauma. Specifically, this chapter focuses on trauma and associated risk factors that influence normal growth and development and how these developmental deficiencies negatively influence children's abilities to form secure attachments. The symptomology of Reactive Attachment Disorder will follow, along with treatment implications for mental health counselors and other professionals. Effective and promising treatment approaches for children with Reactive Attachment Disorder will conclude the chapter.

Early Childhood Development: The Healthy Prototype

Secure attachment relies heavily on the healthy development of children, starting in utero, through the birthing process, and then continuing throughout the first several years of children's lives. This section forms the foundation for what the normal and expected outcomes of healthy development are in children in terms of neurological,

physical, social and self-development and will provide a basis of comparison for subsequent sections.

Neurological Development

During the first three years of development, research in neurological development has indicated that the human brain develops to 90% of its adult size (Perry, 2000a). During this sensitive three-year developmental period, children must receive sufficient sensory stimulation in order to do such things as learn and understand language, develop vision, recognize and regulate their emotions, and understand love. The brain develops in a bottom-up fashion. The brainstem develops first and becomes somewhat resistant to change, whereas other parts of the brain, such as the limbic system and cerebral cortex, can be more influenced by environmental experiences throughout the course of life (Brien, n.d.). The function of the brain stem is to regulate heart rate, blood pressure and emotional arousal. The limbic system is the heart of emotional regulation and attachment capabilities in the human brain. Throughout evolution, the limbic system has served as a survival center, monitoring 'fight or flight' responses (Levy & Orlans, 1998). There are three divisions within the limbic system. The *amygdala* regulates aggression and emotional expression; the *mammillary* section of the limbic system manages maternal attachment-related activities such as nursing and the *sextal* portion integrates affectionate and sexual behaviors that promote procreation (Levy & Orlans, 1998). The cerebral cortex is designed for a human's ability to have abstract cognition and develop complex language (Boykin & Jensen, 2004). During the critical first three years of life,the specificity or generality of each part of the brain is determined as the neurons differentiate and develop into established functions (Brien, n.d.). Also referred to as the

"triune brain" (MacLean, 1978, cited in Levy & Orlans, 1998), the brainstem, limbic system, and cerebral cortex develop specific functions throughout the course of a child's development; the success of healthy brain development relies on appropriate stimulation and nourishment during critical windows of developmental opportunities.

Physical Development

From birth to eight months of age, infants begin to develop dexterity (such as the ability to hold things) as well as purpose-driven movements (such as crawling or holding head up) (Levy & Orlans, 1998). Large and small muscle activity in daily play and exploration becomes evident and infants seem to be fascinated with their strength and body functions (White, 1985). From eight to eighteen months, dexterity becomes more advanced as infants gain control of their bodily movements (Levy & Orlans, 1998). By three years of age, toddlers will display increased manual dexterity, as shown through more complicated activities (such as turning book pages or cutting with scissors), as well as competence in activities such as tying shoes, getting dressed, or feeding themselves.

Emotional Development

Regarding normal emotional development, infants from birth to eight months old will gain the ability to express a broad range of emotions and to depend upon a reliable caregiver for protection and nurturing (Levy & Orlans, 1998). From eight months to eighteen months of age, infants learn the capacity to express intense emotions and, most importantly, to strengthen and solidify attachment feelings as exhibited through attachment behaviors that show that the infants feel secure with the caregiver in or out of his presence. Overall, during the first year or so, infants will frequently display a variety of emotions but can generally be satisfied by loving attention (White, 1985). By three

years of age, young children will display an increased level of control over their feelings, primarily because of the children's ability to use the caregiver as a model for appropriate affect regulation (Levy & Orlans, 1998). Children of this age will also become more attuned to their caregiver's emotional states. This skill will positively benefit the child if the caregiver is a suitable and healthy example of how to effectively regulate emotions.

Social Skill Development

The healthy development of social skills is imperative in children's success throughout their lives (Levy & Orlans, 1998). Newborns show first signs of sociability by making eye contact and smiling when being held (White, 1985). By eight months old, the infant's primary means of communication is crying, facial expressions, and gesturing movements towards the primary caregiver (Levy & Orlans, 1998). By eighteen months, verbal skills increase to facilitate communication, and specific pointing or reaching develops. Crying, cooing, and gurgling are some infant preverbalizations that can elicit social reactions from their caregivers (White, 1985). During this age, infants look to their caregivers as models for how to verbally or nonverbally express their feelings. By the time toddlers reach three years of age, vocabulary skills expand dramatically, but at the same time there is some frustration exhibited when toddlers are not able to accurately verbalize what they need or what they are feeling (Levy & Orlans, 1998). It is at this time that a young child needs the supportive guidance of a caretaker that can help the child articulate his needs and wants. A child of this age enjoys storytelling and can recount events of yesterday, today, and tomorrow.

Development of Self

Children's healthy development of self-concept plays an important role in building confidence in them as well as builds trust in others. By eight months old, infants have awareness of their bodies and how they influence the environment around them. They are able to develop trust in caregivers to meet their needs and provide security and have also learned rudimentary self-soothing skills (Levy & Orlans, 1998). By eighteen months, infants have the ability to internalize messages received from caregivers and, as a result, develop self-esteem based on the content of the message. By three years of age, toddlers develop a sense of autonomy and self-identity through the confident exploration of the world around them. The internalization of caregiver messages continues to solidify toddlers' working model of themselves and others, and they also feel a sense of belonging (Levy & Orlans, 1998).

By three years of age, children experience critical developmental opportunities that set the stage for continued growth and a positive outlook towards self and others. Many children have the fortunate opportunity to experience a nurturing childhood in which their development is fostered in healthy, secure, and encouraging ways. The next section examines a specific feature of child development that permeates throughout nearly all aspects of the child's life: attachment.

Developmental Attachment

Throughout the course of healthy childhood development, an important phenomenon occurs that creates a lifelong impact on how human beings view themselves, others, and the world. Rooted in a basic human need for support and survival, attachment to others provides a sense of security and protection during times of

stress and serves as a prototype for how to respond to others and the world (Levy & Orlans, 1998). Attachment is consistently viewed as a deep and enduring psychological connection between individuals, beginning with the unique bond between mother and infant during the first few years of the infant's life (Bowlby, 1969; Evergreen, n.d; Perry, 2000a). While the development and maintenance of attachment is important throughout the life cycle, healthy attachment is of critical importance during an infant's first eighteen months of life, as this is the time that infants begin to develop trust that others will provide security and reliability that validates that the world is a safe and nurturing place (Kagan, 2004). Furthermore, researchers suggest that attachment can begin before birth, as it has been noted that a five-month old fetus can begin to recognize the sound of its mother's voice (Feinberg, n.d.). Attachment is commonly identified as an interpersonal process of reciprocal emotional influences between a parent and child that form a deeply connected emotional relationship (Levy & Orlans, 1998). This significant emotional relationship sets the tone for how infants will develop subsequent relationships, as well as how infants grow up viewing themselves, others, and the world around them (Perry, 2000a).

The quality of attachment between a mother and child significantly influences the child in nearly all facets of his development including cognition, behavior, socialization, emotional regulation, physical and moral development (Evergreen, n.d.). Since the quality and consistency of the relationship between the child and the attachment figure is such a dominant element in successful child development, attachment is viewed as a significant base from which the child establishes future social relationships and develops positive emotional health (Becker-Weidman, n.d.). Healthy attachment is critical in that

it provides children with safety and protection, teaches children trust to explore the world with both security and independence, helps children regulate their emotions and impulses and creates a positive sense of self and others (Levy & Orlans, 1998).

History of Attachment Theory

Historically viewed as similar to object-relations theory, attachment theory defines and emphasizes the human need for close, emotional connectedness (Karen, 1998). As a psychoanalyst, John Bowlby stood out in his field because he started to explore and ask questions that challenged and expanded upon Freud's theories of motivation. Bowlby suggested that attachment theory contains a theory of motivation and control that describes infants' tendencies to keep attachment figures close or at bay (Bowlby, 1988). In the early 1900's, concern for a child's home life was slowly coming into view as an imperative determinate for mental health, and Bowlby recognized that environmental influences played a part in forming children's attachment behaviors (Bowlby, 1988; Karen, 1998). Bowlby (1969) was one of the earliest researchers to propose the notion that early, significant relationships profoundly influence a child's ability to form healthy, meaningful relationships later in life, believing that the first relationship an infant develops (usually with mother) determines the health and well-being of the infant's progression through life (Karen, 1998).

In the 1950's and 1960's, Bowlby's attachment theory was developed and rooted in the belief that attachment is biologically-based as people and animals have instinctual drives towards protection and survival (Bowlby, 1969; Peluso, Peluso, White & Kern, 2004). Instinctively, infants are motivated to display bonding behaviors to promote attachment with others, as they are defenseless and seek out a relationship with a trusted

caregiver that will provide both protection and guidance. In times of perceived danger or threat of danger, infants will increase their attachment behaviors towards a trusted caretaker as a means of survival. Physical protection and emotional well-being rely on the security of an attached relationship (Delaney, 1998; Perry, 2000a). Furthermore, without the security of a nurturing, protective relationship with a caregiver, children significantly suffer, as Bowlby reported in his monograph entitled, "Maternal Care and Mental Health" which he published through the World Health Organization in 1951 (Bowlby, 1988). This monograph supported the idea that children with significant deprivation early in life will be likely to have profound emotional, social, and physical difficulties (Bowlby, 1951; as found in Levy & Orlans, 1998).

There is an instinct and need to seek out affectionate relationships with others at times of increased vulnerability (Karen, 1998). In refining his theory of attachment, Bowlby (1969) suggested that attachment behavior serves both an instructive and protective function. Attachment theory attempts to explain the functions of these behaviors. Attachment behaviors serve an instinctual purpose that develops within infants as the result of ongoing interaction with an attachment figure and with the environment. In other words, attachment behavior is defined as any behavior in which an individual seeks proximity towards an attachment figure that can both protect the individual and model how to effectively cope with the world. This type of attachment behavior is most commonly witnessed in infancy and early childhood. Within the first year alone, attachment development can be clearly identified in infants by the presence, or lack of, attachment-eliciting behaviors (Crittenden & Ainsworth, 1989). During times of increased stress and threat of danger, infants will actively seek out an attachment

figure for protection. At times when there is no perceived threat, infants feel safe to branch away from their attachment figure to explore the world, secure in the fact that the attachment figure will still be there and that the relationship will continue to grow and be maintained (Bowlby, 1969, 1988).

As Bowlby (1969) continued to study attachment behaviors, he divided the cycle of attachment into four stages: preattachment, recognition/discrimination, active attachment, and partnership (Delaney, 1998; Watkins, 1987). In the *preattachment* stage, lasting from birth to about three months old, infants are vulnerable and therefore completely dependent upon a caregiver. At this early stage, infants haven't made an accurate distinction or preference for a particular caregiver and the predominant behavior used to elicit attention from a caregiver is crying (Bowlby, 1969; Watkins, 1987). Starting at about twelve weeks old, infants move into second stage, also referred to as the *recognition/discrimination* stage. Bowlby (1969) indicates that it is during the infants' first four to six months of his first year that they will be most sensitive to the development of attachment. In this stage, infants begin to visually recognize and show preference to a particular caregiver. This becomes noticeable in that infants will react in distinct ways (crying, smiling, etc) toward a particular caregiver and different ways towards others (Delaney, 1998; Watkins, 1987). Between eight months old and three years old, infants and toddlers will move into the third stage, *active attachment* (Delaney, 1998; Watkins, 1987). As in the second stage, infants will show clear discrimination between their attachment figure and other individuals by expression anxiety in both separation and in the midst of strangers. It is in this stage that infants will continually check the environment for the caretaker and, if present, infants will then show confidence

in exploration of their immediate environment. The security of the nearby attachment figure provides a base from which infants and toddlers can explore (Delaney, 1998). Finally, at about three years of age and beyond, young children move into the *partnership* stage. At this final stage, attachment is strong and solid within children and they see their parents as independent beings (Delaney, 1998; Watkins, 1987).

Although each successive stage is more developed and advanced than the previous one, the common thread throughout is the importance of consistency. Researchers have likened this consistency to a form of behavioral conditioning, instilling in the child that significant relationships between human beings equate to comfort, security, trust, and stability (Wilson, 2001).

Significant Attachment Research and Developments

John Bowlby (1988) asserted that many questions still remained unanswered throughout the 1950's and 1960's regarding attachment development and the early causes of behavioral disturbances in children. Some disagreements about parenting also surfaced, as some researchers believed that children can only be parented by their birth mother (the 'blood-tie' theory) and that mothers should care for their children continuously without respite. There are several researchers that have contributed to the study of attachment and bonding behaviors that have helped to refine and identify attachment patterns, classifications, and theory development. Early research in attachment helped to identify the role that parenting and child-rearing played in the development of attachment patterns (Kagan, 2004).

Much of the work of Harry Harlow involved the effects of maternal deprivation on infants and he used monkeys as models for studying attachment behaviors (Bowlby,

1988). During the late 1950's, Harlow used rhesus monkeys in a laboratory setting to examine their attachment behaviors towards warm, affectionate mothers versus cold, uncomforting mothers. Harlow made soft cloth "dummies" to simulate the mothers that provided warmth and a sense of security to the infant monkeys. Some of the infants were raised with these, and some were raised with cold, uncomforting dummies. What he discovered was that if the monkeys raised with the cloth dummies were put into an unfamiliar environment, the monkeys would actively seek out the dummy for security, clinging to it in terror, and then would climb off of it and actively explore the environment (Kagan, 2004). Furthermore, Harlow concluded that infant monkeys preferred soft cloth dummies that did not provide food to cold, uncomforting dummies that did provide a food source (Harlow & Zimmerman, 1959, cited in Bowlby, 1988). These findings helped supported his conclusion that a sense of safety, security and comfort provided by a caregiver are extremely important in the healthy development of infants.

Bowlby (1988) also borrowed from the work of Konrad Lorenz in studying natural human instincts towards bonding behaviors and attachment formation. Similar to some of the conclusions drawn by Harlow, Lorenz explored the idea that a strong bond to a mother figure can instinctively develop without the involvement of food or any other type of reinforcer. Lorenz's work in 1935 involved the responses of ducklings and goslings to a mother-figure; they would to fall in line instinctually. This idea of "instinct" fascinated Bowlby in his quest to learn about the bonding and attachment process in human beings and how this new approach to explaining human behavior would impact psychoanalysis (Bowlby, 1988).

In the early 1950's, Mary Ainsworth spent about three and a half years working with Bowlby on attachment research (Kagan, 2004). In 1954, Ainsworth pioneered infant attachment research in Uganda and published empirical studies (Ainsworth 1963, 1967, cited in Bowlby, 1988) focusing on how children progress both emotionally and cognitively (Bowlby, 1988; Kagan, 2004). When working with Bowlby, she explored his research question of 'what is going on between a mother and child during early development (that results in impairments in attachment)?' to guide much of her research in Africa. Early in the 1960's Ainsworth continued research with infants at Johns Hopkins University and made significant discoveries regarding different types of attachment classifications as well as the conditions necessary for healthy attachment to occur (Kagan, 2004). Her work supported what Bowlby was already strongly asserting, that the quality of the mother/infant relationship early in life is crucial to healthy development and attachment formation (Kagan, 2004).

A laboratory study that Ainsworth labeled the 'strange situation' identified three different attachment classifications: securely attached, avoidant, and resistant (Ainsworth, Bell, & Stayton, 1971; Ainsworth, Salter, Blehar, Waters, Everett, & Wall, 1978, both cited in Bowlby, 1988). This laboratory experiment involved two brief infant/mother separations and, during the separation, the infant is left with a stranger. Upon reunification, the reaction of the infant to the mother was noted and was the basis of identifying the mother and child characteristics associated with each of the three attachment patterns (Karen, 1998).

Babies that actively sought out their mothers and did not resist affection upon reunification during the 'strange situation' experiments were described as being *securely*

attached (Ainsworth, et al., 1978, cited in NAIARC, 1999). The infants showed confidence that their caregivers would be available and responsive, and the mothers were actively affectionate and attentive towards their infants (Bowlby, 1988; Levy & Orlans, 1998).. The 'strange situation' identified that infants with secure attachments were easily comforted by their mothers and the comfort of knowing that the mother was available allowed the infants the emotional security to explore their immediate environment knowing that the 'secure base' (his mother) was nearby (Ainsworth, et al., 1978, cited in NAIARC, 1999; Bowlby, 1988). The parenting style that promotes secure attachment is shown by parents who are readily available, emotionally sensitive, attuned to their child's wants and needs, and is lovingly responsive when the child seeks out security and comfort (Bowlby, 1988).

As demonstrated through the 'strange situation' experiment, infants are described as having *insecure-avoidant attachment* if there is evidence of clear avoidance of the mother upon reunification. (Ainsworth, et al. 1978, cited in NAIARC, 1999). This avoidance can include lack of eye contact, physically turning away, as well as appearing to be more easily comforted by the stranger than by the mother (Boykin & Jensen, 2004). Insecure-avoidant attachment patterns result from infants' lack of confidence that caregivers will respond in a predictable manner to their needs. Therefore, they come to expect that others will not be responsive to them (Bowlby, 1988).

Infants with an *insecure-ambivalent attachment* pattern are not able to predict whether or not a caregiver will be readily available (Bowlby, 1988). Feelings of anxiousness are common because the unpredictability makes it difficult for the infants to know what to expect. In the 'strange situation' experiment, infants described as having

an insecure-ambivalent attachment were ones that did not explore their surroundings in the presence of their caregiver and displayed obvious resistance towards their caregiver upon reunion after a brief separation. Initially seeking out comfort but then immediately pushing away and resisting the affection is a common behavior in infants with insecure-ambivalent attachment patterns (Ainsworth, et al., 1978, cited in Wilson, 2001). The contradictory behavior is baffling as the infants seek out their caregivers upon reunion, but then quickly push away and are inconsolable by the caregivers (Ainsworth, et al., 1978, Main & Hesse, 1990; both cited in Delaney, 1998).

Ainsworth and her colleagues discovered three important attachment classifications, but not all infants seemed to fit nicely into one of these categories. Main and Solomon (1986) (cited in Wilson, 2001) identified a fourth attachment pattern in infants who displayed incoherent patterns of reactions to separations and reunions with their primary caregivers. With this *disorganized/disoriented attachment* pattern, these infants appeared to lack goal-driven behavior; instead, behaviors seemed to show confusion and apprehension especially when in the presence of their caregivers. The contradictory behaviors of continually wanting to approach the caregiver, yet at the same time stay away, are very distressing and are commonly seen in children who have experienced severe trauma during critical times of attachment development (Delaney, 1998; Main & Solomon, 1986, cited in Wilson, 2001). Furthermore, it has been hypothesized that this disorganized attachment pattern results from infants who are not only frightened by their primary caregivers, but also seek out their caregivers as a source of reassurance (Boykin & Jensen, 2004; Main & Hesse, 1990, cited in NAIARC, 1999).

Of all four attachment patterns, the disorganized/disoriented attachment pattern is most common in infants and children who have a history of traumas such as abuse, neglect, or other violence (Boykin & Jensen, 2004). Children's lives are chaotic and they approach any form of affection with reservation and mistrust due to the history of unpredictability and fear brought on the by their caregivers. As a result, these children do not have a stable base from which to learn coping strategies and emotional regulation. The person that they are supposed to feel the most comfort from and learn from is the same person creating feelings of anxiety, fear, and mistrust. The combination of this negative parental influence and the resulting negative cognitive structure that builds within the child increase a child's susceptibility towards developing an attachment disorder. The following section will discuss more specifically how healthy attachments are developed, maintained, and manifested.

Development and Manifestation of Healthy Attachment

The Fundamental Needs of a Child

In order to ensure that children will successfully pass through the stages of secure attachment development and emerge confident and well-adjusted, there are five key components that must be in place. These "fundamental needs", as they are described in a commentary in the Brown University Child and Adolescent Behavior Letter (Tylenda, 2004), are consistently reported throughout attachment research as key factors in predicting a successfully attached child. All of the needs intertwine and work together to create a stable, safe environment. The first need indicated is *structure*, or routine. Children use structure as a means of stability and organization in their lives and rely on it when they may feel lost or confused. The second need, *consistency*, refers to the

uniformity of the structure that fosters *predictability,* the third fundamental need. When children can predict how caregivers and the world will respond, less energy is spent on anxiety and worry and the energy can be expended in more productive ways. Predictability is also important in the building and maintenance of trust. The fourth need, *non-punitive limit-setting*, provides consequences that children can expect when the guidelines for behavior are well-established. The final need, *nurturance,* provides children with unconditional love, protection, and guidance that is critical to secure attachment development.

The Bonding Cycle

The terms 'bonding' and 'attachment' tend to be used interchangeably, but researchers have made clear distinctions between them. Bonding is an action, a behavioral repertoire that children display to elicit responses from the parent (Perry, 2000a). The response from the parents determines if the children's efforts to bond were either validated and enriched, or ignored and deflated. In other words, bonding is the process of forming an attachment with another human being. This section will focus on the bonding cycle characteristics and successful bonding.

The fundamental needs described in the previous section are consistently present and validated in a continuous attachment process between mother and child, commonly referred to as the bonding cycle, or "first year of life cycle" (Chapman, 2002). The fulfillment of the needs throughout this critical bonding cycle is imperative for children to successfully pass through the stages of secure attachment formation and arrive at the end both secure and confident. Since the children's first relationship (generally with their mothers) forms the template for all future relationships, researchers have consistently

argued that the quality of the bonding experience is extremely important in the formation of healthy attachment (Levy & Orlans, 1998; Perry, 2000a).

Infants in the first year of life are quite defenseless and have many needs to be met. The bonding cycle begins with an infant expressing a *need*, such as hunger, wetness, pain, discomfort, or a desire to be held or touched (Feinberg, n.d; Keck & Kupecky, 1995, 2002). Infants will express this need by *displaying attachment-eliciting behaviors* such as crying, fussing or in any other way showing caregivers that they have a particular need to be met (Becker-Weidman, n.d.). For a healthy bond of attachment to occur, caregivers will then respond to infants' arousal by *gratifying the need* through such actions as feeding, changing, holding, or comforting. Researchers have indicated that one of the most important aspects in the facilitation of secure attachment is comforting physical contact such as rocking, holding, or hugging (Perry, 2000a). In addition, the infant-caregiver gaze is an important cue that successful bonding and attachment is occurring (Levy & Orlans, 1998). An important concept to address here is attunement, the ability to be accurately and sensitively aware of children's needs and responding in an effective way (Perry, 2000a). If caregivers are able to accurately read and respond to the non-verbal cues they are receiving from their infants, then they are able to effectively interact with their infants in a mutually satisfactory way.

When caregivers consistently show affection and attention toward infants who are expressing a need and the need is gratified, the cycle is successfully completed as the infants grow to *develop trust in their caregivers* and the infants' needs are validated as important and worthwhile (Feinberg, n.d.; Levy & Orlans, 1998; Sheperis, Renfro-

Michel, & Doggett, 2003). The deeper the trust, the easier the infants can handle their needs and feel secure that their needs will continue to be met (Kagan, 2004).

The bonding cycle is successful if it is consistent, predictable and repeated. The desired and expected outcome are children that can give and receive love, as well as come to expect that their needs will consistently be met (Becker-Weidman, n.d.). The repetition of the need-arousal-gratification-trust cycle happens continuously throughout the infants' first year of life, and this repetition is what creates the development of trust that is so critical for infants to establish early in life. Some researchers contend that the bonding cycle is a reciprocal process, the mother and child simultaneously influencing each other and deepening the attachment. When infants' needs are successfully gratified through their mother's nurturance and loving attentiveness, infants develop safe, positive feelings about their mothers. In turn, the positive behaviors displayed by infants as a result of having their needs met bring satisfaction and pleasure to the mother (Perry, 2000a).

Healthy Parent Characteristics and Responses to the Child

The bonding cycle is an important facet of a child's development in that it helps a child not only establish trust and security in others, but infants and young children regard their primary caregiver as a prototype of how to respond and react to others as well as how to control themselves. For example, researchers have indicated that children regard their parent's emotional state of mind as a framework from which to regulate themselves (Becker-Weidman, n.d.). Teaching children skills that will help them to modulate their emotional levels can be considered an extremely important role for parents (van der Kolk 1996, cited in Levy & Orlans, 1998). These first relationships, therefore, are intensely

crucial and rely heavily on the quality of parental skills and characteristics, especially how parents respond to their children. This section focuses on parent characteristics and responses that facilitate secure attachment in children.

Responsiveness, sensitivity, and accessibility are three important characteristics of healthy parents (Becker-Weidman 2002; Delaney, 1998; Lyons-Ruth, Connell, & Zoll, 1989). The strong presence of these qualities in parents throughout the first three to five years of their children's lives helps to ensure the development of secure attachment (Kagan, 2004). Response to a children's emotional state is an important factor in the maintenance of healthy attachment and the prevention of unhealthy attachment development (Becker-Weidman, 2002). When mothers are attuned to their infants and respond to them through touch, words, or gaze, the infants will begin attaching to them, ultimately establishing them as a safe and secure "base" from which to explore the rest of the world (Feinberg, n.d.). When parents are accessible and available both physically and emotionally to their children, bonding behaviors are more likely to occur, thus facilitating the healthy development of attachment (Delaney, 1998). A mother who experiences maternal enjoyment contributes to the healthy attachment process as well, as infants are able to pick up on these positive feelings (Lyons-Ruth, et. al, 1989).

Attunement is an important parental characteristic in that it serves many purposes in the development of healthy relationships and children's healthy self-concept (Kagan, 2004). Being able to accurately read and respond to the needs the infant is an important parental characteristic that fosters quality attachment (Perry, 2000a). Attachment experts indicate the importance of parents being fully aware of the significance of the attached relationship they have with their children and to impose firm and loving discipline in the

context of clear boundaries and natural consequences (Kagan, 2004). Providing a secure, loving relationship is important for the parent to do because the child will always know that, even though the parent was angry, the relationship is still strong and continually validated and reaffirmed (Kagan, 2004). Also, this helps teach children how to self-regulate and become more independent in monitoring their feelings and behaviors. Consistent discipline with firm limits, provided in the context of acceptance, love and empathy, creates a nurturing and protective way to impose discipline (Kagan, 2004).

How Secure Attachment Manifests in Children

When children have repeatedly experienced healthy, loving cycles of bonding with primary caregivers who provide security, predictability, nurturance, consistency, and structure, children develop secure attachment. Most researchers support the fact that children with secure attachment fare better than children with insecure attachments in all areas of development (Levy & Orlans, 1998). This section focuses on the manifestation of secure attachment in childhood in terms of behavior, affect, cognition, social skills, and moral development.

Behavior. The behavior of children with secure attachment is evident in how they react and respond to their primary caregivers. Children exhibit attachment behaviors that are intended to keep the caregiver close, especially during times of danger or perceived threat (Delaney, 1998). Some of these behaviors include: eye contact, smiling, following, searching, reaching, signaling or calling to, and seeking to be picked up (Delaney, 1998). As securely attached children get older, they are able to understand consequences of their actions, display goal-oriented behavior, and exude confidence in play activities (Kagan, 2004).

Affect. As a result of healthy bonding behaviors and positive parenting, securely attached children will display the ability to self-regulate their emotions and impulses, to feel and show empathy, affection, and understanding, and to regulate their emotions (Feinberg, n.d.; Glatz, 1998). Through the development of trust based on the significant relationship with primary caregivers children are able to develop other emotional relationships as well (Evergreen, n.d.).

Cognitive Structure (Internal Working Model). The 'internal working model' is a fundamental aspect of cognitive development that provides a framework for how children sees themselves, others, and the world (Boykin & Jensen, 2004; Delaney, 1998; Peluso et al., 2004). Based on early attachment experiences, children develop a cognitive framework based upon their expectations of themselves and others. The internal model is continually validated by reinforcements from primary caregivers. Responsive and accessible parents instill in securely attached children that parents are people who are 'available, responsive, and will meet my needs' (Delaney, 1998). As beliefs about self and others are continually validated by the attachment experience, the beliefs become more internalized (Levy & Orlans, 1998). Children's schemas, the lens through which they see the world, are heavily influenced by these experiences. Bowlby (1969) regards a positive internal working model to be one that is an "optimistic expectation" of how children view themselves, others, and the world. Securely attached children will have more positive self-esteem and have a more positive outlook on the world than children with unhealthy attachment patterns (Delaney, 1998; Levy & Orlans, 1998).

Social Skills. Securely attached children have developed significant trust in others stemming from a healthy primary relationship with caregivers. As a result of this trust

that the caregiver will always be there, children will feel confident to explore the world and try out new social relationships (Evergreen, n.d.). Furthermore, without the extra energy expended in worry or fear that the caretaker will be gone, children will be able to effectively direct their energy on play and the development of mastery (Delaney, 1998). Interpersonally, children who are securely attached will not feel a strong desire to be in control of all situations. They can get along well with others and have a sense of self-awareness when around others. Since children who are securely attached have been able to learn how to regulate and appropriately display emotions, they can quite easily give and receive affection (Kagan, 2004). When parents provide consistent and accurately responsive care, strong social skills develop within children. Overall, securely attached children tend to be good, empathic friends to others, as compared to insecurely attached children (Levy & Orlans, 1998).

Moral Development. Securely attached children display a well-formed conscience and can tell the difference between right and wrong (Delaney, 1998). Generally, when children do something wrong, the appropriate feelings of guilt, shame, or anxiety accompany the behavior and they are capable of accepting responsibility for their actions (Kagan, 2004). Children with secure attachments are better able to show empathy and compassion for others (Evergreen, n.d.).

Role of Trauma in Development of Unhealthy Attachment

Not all children experience what it is like to form a loving, secure relationship with a caregiver who is predictable and safe. For some children, trauma such as abuse, neglect, violence, loss, and multiple separations impede a child's ability to form loving, attached relationships with others. As for the frequency and variety of abusive and

neglectful occurrences, the statistics are not reassuring. Nearly four million children in the United States experience trauma each year in the form of physical and sexual abuse, neglect, accidents and injuries, as well as natural disasters (Schwartz & Perry, 1994, cited in Lowenthal, 1999). In 1999, nearly 826,000 children were found to be victims of abuse and/or neglect and the age group found to be the most victimized was that of children from birth to three years old (U.S. Department of Health and Human Services, 2001; cited in Kagan, 2004). In many cases, the source of trauma comes from the very people whom children would expect to receive love, protection and guidance from. Traumatic events early in children's lives can shatter their expectations and perceptions of themselves, others, and the world (Kagan, 2004). When caregivers traumatize infants or toddlers they quickly come to realize that they must act defensively because they learn that no one will be there to protect them (Pickle, n.d.). Early childhood trauma robs children of the opportunity to experience love, safety, and trust. Childhood becomes a time of fear due to the traumatic and uncontrollable circumstances in their lives. The next section reviews various types of childhood trauma that influence attachment development.

Types of Childhood Trauma

The examples of childhood traumas illustrated here mostly involve impairments in the relationship between a caregiver and child. Therefore, this section will outline significant caregiver and child risk factors that ultimately contribute to the inability for children to form healthy attachments. This section will conclude by exploring how the developmental deficiencies due to trauma significantly impact a child's ability to form healthy, secure attachments with others.

Physical Abuse. Child abuse and neglect is defined by the Child Abuse Prevention and Treatment Act (CAPTA) (2003) as "any recent act or failure to act on the part of a parent or caretaker which results in death, serious physical or emotional harm, sexual abuse, or exploitation". Physical abuse is a major source of childhood trauma and is the leading cause of death in children younger than one year (National Clearinghouse on Child Abuse and Neglect 1993, cited in Levy & Orlans, 1998). Researchers have also made clear connections between physical abuse and the development of a variety of disorders affecting behavior, cognition, affect regulation, and interpersonal relatedness, as well as an increase in the stress-response system in the brain (Becker-Weidman, 2003; Brien, n.d.).

Sexual Abuse. Sexual abuse is highly unsubstantiated because of the secrecy and betrayal of trust that is involved. Sexual abuse is defined as the "employment, use, persuasion, inducement, enticement, or coercion of any child to engage in, or assist any other person to engage in, any sexually explicit conduct or simulation of such conduct for the purpose of producing a visual depiction of such conduct", or, "the rape, and in cases of caretaker or inter-familial relationships, statutory rape, molestation, prostitution, or other form of sexual exploitation of children, or incest with children" (CAPTA, 2003). Sexual abuse is a threatening and extremely traumatic experience for children. When working with children with attachment difficulties, a history of sexual abuse is a very common thread (Finkelhor, 1979, cited in Levy and Orlans, 1998).

Incest, or sexual abuse by a family member, is considered to be even more traumatic than abuse from a stranger or non-family member because of the role confusion and the betrayal of trust (Levy & Orlans, 1998). Children who are abused by a family

member do not learn or experience what a protective and secure family member is supposed to be. This confusion distorts a child's world and forces them to distrust others.

Neglect. Chronic disregard for a child's basic physical and/or emotional needs, as well as an act (or failure to act), that results in imminent danger to health, safety, or well-being is considered to be the neglect of a child (Perry, Colwell, & Schick, 2002). Child neglect accounts for nearly 65% of all reported and substantiated child abuse reports (National Clearinghouse on Child Abuse and Neglect, 1995, cited in Levy & Orlans, 1998). Although each state in the United States can determine specific definitions of neglect, there are generally three different categories: physical, emotional and educational (Levy & Orlans, 1998; National Clearinghouse on Child Abuse and Neglect (NCCAN), 2004; Perry et al., 2002). *Physical neglect* includes abandonment, refusal to allow a runaway to return home, expulsion from the home, or refusal and/or delay in seeking medical treatment (NCCAN, 2004; Perry et al., 2002). *Emotional neglect* refers to the lack of attention, support, or affection that a caregiver provides to a child. This can include things such a allowing a child to use alcohol or other drugs, inadequate supervision, failure to provide support or comfort when needed, or domestic abuse in the presence of a child (NCCAN, 2004; Perry et al., 2002). The results of the longitudinal Minnesota Mother-Child Project indicated that a mother who is emotionally unavailable to her child is actually more harmful to the child than physical neglect or any other form of maltreatment (Erikson, Egeland, & Pianta, 1989). *Educational neglect* involves a parent allowing their child to be truant, a failure to enroll a child in school at the proper age, or neglecting the child of any special education needs that he may have (NCCAN, 2004).

Domestic and Community Violence. In 1997, it was noted that over 3.3 million children lived in homes in which domestic abuse occurred (Kaufman, 1999, cited in Kagan, 2004). Security, trust, and love are all critical aspects surrounding children's healthy development and when young children witness graphic violence between people that are supposed to be providing care their sense of safety is threatened. Children who grow up in homes with domestic abuse or live in environments stricken with the devastation of war are vulnerable to developing attachment difficulties due to the fear and instability that is prevalent and the love and security that is lacking (Perry, 2000a). Witnessing violence between people with whom children have close relationships increases the trauma (Monahon, 1993). Domestic abuse is correlated with the maltreatment of children within the home (Strauss, 1993, cited in Levy & Orlans, 1998). The victims of domestic violence (in most cases the mothers) continue to perpetuate the cycle of violence and the children then become victims of abuse as well. The recapitulation of violence within the family unit continually confirms to the child that their immediate world is dangerous, chaotic, and insecure (Kagan, 2004). Furthermore, violence within the home is just one aspect of the trauma that the child can experience. The death of a family member due to violence or being placed out of the home due to excessive danger and violence in the home are traumatic as well (Monahon, 1993).

Exposure to dangerous and threatening community violence is also a source of trauma for infants and young children. Infants and young children are very adept at picking up on their caregivers' emotional responses to environmental threat. Children are aware of how their caregivers are responding to traumatic events and are strongly

influenced by the caregiver's coping strategies (Strauss, 1993, cited in Levy & Orlans, 1998).

Separation and Loss. Since security, predictability, and consistency are fundamental to the healthy upbringing of children, multiple separations from caregivers and other disruptions can be traumatic for children. Intellectual, social, emotional, and behavioral functioning are all at risk if a child experiences multiple moves and a variety of different caregivers at a young age (Becker-Weidman, 2002).

Associated Risk Factors Influencing Attachment

In the previous section, various types of childhood trauma were introduced that threaten children's abilities to form healthy, attached relationships. This section addresses specific parent/caregiver and child risk factors that contribute to insecure relationships and foster the development of attachment disorders.

Parent/Caregiver Risk Factors. The *emotional availability* of a caregiver is a risk factor for the development of attachment difficulties if the availability is rejecting or nonexistent (Boykin & Jensen, 2004; Keck & Kupecky, 2002; Perry, 2000; Rosenstein & Horowitz, 1996). When the caregiver's parenting style lacks positive emotion and is instead clouded with critical, harsh and rejecting messages, children will have a tendency to internalize these negative messages as a way to understand themselves, others, and the world, as well as grow up to avoid emotional intimacy with others (Perry, 2000a; Rosenstein & Horowitz, 1996). If parents are unable to acknowledge the positive aspects of their children, it is likely that the children will not be able to acknowledge positive qualities within themselves either (Bowlby, 1988). Without positive emotional regulation and consistent affection, young children will have a difficult time experiencing bonding

and attachment to their parents or caregivers and, as a result, suffer behavioral and psychological consequences (Keck & Kupecky, 2002). Furthermore, if a caregiver's emotional responsiveness is chaotic, unpredictable, and creates an artificial feeling of closeness, children receive confusing messages and may not feel a strong attachment toward the caregiver (Levy & Orlans, 1998).

Pathogenic care, such as a consistent lack of attention to children's physical and emotional needs, is a parenting risk factor for children to develop attachment difficulties (Boykin & Jensen, 2004). Pathogenic care can be a result of significant impairments within the caregiver. If caregivers suffer from mental or physical limitations there is an increased chance that their children will not sufficiently develop attachments due to their inability to be completely emotional and/or physically available (Perry, 2000a). In addition, if the mother suffered abuse and/or neglect in her own childhood, it is likely that the abuse cycle will repeat with her own children (DeLozier, 1982; Keck & Kupecky, 2002). DeLozier (1982) proposed that parental characteristics such as fearfulness, anxiousness, hostility, depression, and difficulties with decision-making contribute to maladaptive attachment patterns within their children. In addition to maternal depression, overwhelming problems or significant drug and/or alcohol use may dramatically influence a mother's ability to be fully present and attentive to her child (Perry, 2000a). Furthermore, ignorant and overwhelmed parents may become preoccupied with their own personal issues and not realize that they are not providing the emotional consistency that their children need (Perry et. al, 2002). Caregiver insensitivity and unawareness can get in the way of infants' goal-directed behavior because without the security of a consistent, nurturing base, infants will be less inclined

to explore the immediate physical and social environment, depriving themselves of enriching experiences that will further promote cognitive, language and social development (Crittenden & Ainsworth, 1989; Lyons-Ruth, et. al., 1989).

Child Risk Factors. There are several early childhood risk factors that could make a child more vulnerable to developing attachment difficulties. Infants' temperament can significantly influence the ability to bond and form attachments with caregivers (Perry, 2000a). An irritable temperament may make it difficult for infants to be soothed and comforted, therefore compromising the ability for parents and infants to form a secure attachment (Levy & Orlans, 1998). In addition, medical conditions such as prematurity, birth defects, congenital/biological impairments, and other illnesses are contributing factors in the development of attachment disorders. These conditions may prevent infants from taking an active role in bonding to their caregivers during critical development periods (Levy & Orlans, 1998; Perry, 2000a). Finally, in utero exposure to persistent stress, as well as alcohol and/or drug exposure can cause significant neurological and physical impairments that hinder the ability for an infant to form healthy attachments (Levy & Orlans, 1998).

Developmental Deficiencies and Attachment Development

As indicated in the previous sections, there are various types of childhood trauma that severely influence a child's ability to form attachments and there are contributing parent and child risk factors associated with these particular sources of trauma. This section examines how trauma causes deficiencies in various areas of child development and how these deficiencies impact a child's ability to form securely attached relationships.

Neurological. Trauma early in life is known to cause significant neurological impairments in developing children because it is in the early years that the brain and nervous system are rapidly developing (Kagan, 2004; Perry et al, 2002). Several specific parts of the brain are significantly influenced by trauma-induced stress or lack of critical experiences early in life; the brainstem and midbrain become overdeveloped in both physiology and function, resulting in increased anxiety, poor affect regulation, impulsivity, and motor hyperactivity. Subsequently, the limbic and cortical physiology and functions are underdeveloped, significantly influencing problem-solving skills and empathy building (Boykin & Jensen, 2004; Brien, n.d.).

When high stress due to traumatic, frightening experiences or a lack of loving touch and security is prevalent in a child's early development, the natural stress response system will become overly active and/or reactive (Boykin & Jensen, 2004; Levy & Orlans, 1998). Lack of loving touch and a sense of security produce increased stress hormones that can effect brain and body development (Evergreen, n.d.). One of the most significant effects of trauma early in a child's life is the over-production of the stress hormone cortisol, which is due to the intense and chronic exposure to danger or threat of danger (Balbernie, 2001, cited in Chapman, 2002). The significantly heightened production of this corticosteroid can cause parts of the brain, such as the limbic system to develop 20% to 30% smaller than a normally developing brain (Brien, n.d.).

When the brain is producing an excessive amount of stress hormone during critical periods of development, fear responses ('fight or flight') become established as normal and infants tend to live in a constant state of hypervigilance and stress, the brain is altered to focus merely on survival, and the focus is taken away from more well-

rounded development (Boykin & Jensen, 2004; Lowenthal, 1999). When infants continually feel a sense of fear due to pain or threats, this fear impedes infants from being able to develop healthy relationships and secure attachments as their basic sense of trust and security is shattered and their environments are chaotic (Perry, 2000a).

Physical. When severe and persistent neglect in a child's first few years is prevalent, the child's physical and neurological development is significantly disrupted because early childhood is a time when the development is rapid and critical (Perry, et al., 2002). In fact, physiological changes due to trauma can cause the most drastic, long-lasting damage during the time from conception throughout the child's first years and impair a child's ability to form meaningful connections with others (Kagan, 2004).

Specifically, the effects of neglect such as improper nutrition and lack of emotional stimulation cause an altered releasing pattern of growth-regulating hormones. When deprived of these essential components, physical development is compromised, resulting in 'failure to thrive' syndrome (Perry, et al., 2002). Some general physiological responses to trauma include chest pains, fatigue, increased heartbeat and increased blood pressure (Lerner and Shelton, 2001b, cited in Kagan, 2004).

Behavioral. Children who witness and/or are victims of violence develop a variety of behavioral disturbances that are not conducive to healthy development. For example, children may become more aggressive in their play as they act out behaviors that they have seen within the home or community (Levy & Orlans, 1998). Children who experience sexual abuse and violence grow up feeling as though there is no one to trust and their outwardly aggressive sexual and violent behaviors are examples of how these children are trying to conquer a world that has hurt and betrayed them so badly (Kagan,

2004). Peculiar coping and soothing behaviors become apparent in a child during times of high stress including banging his hand, biting themselves, rocking, and scratching themselves (Perry, 2000b).

Emotional. Many of the developmental deficiencies that children experience due to trauma are in the areas of emotional regulation and affect attunement including interpersonal connectedness, sympathy, and empathy (Becker-Weidman, 2003; Monahon, 1993). Difficulty regulating their own emotions and accurately recognizing emotion in others are the result of the malformation of the brain system due to the overproduction of stress hormones and poor integration of the cerebral hemispheres brought on by excessive trauma and stress (Becker-Weidman, 2003; Lowenthal, 1999). Furthermore, children that have suffered from trauma may simply not know now to show emotion, shut down, and withdraw from others, making it difficult for people to try and connect with them (Brien, n.d.). Significant disruptions of attachment as a result of trauma cause children to be unable to give and receive affection, thus hindering any possibility at close relationships with others (Evergreen, n.d.).

Symptoms of post-traumatic stress disorder develop as a result of severe trauma (Monahon, 1993). Some of these PTSD symptoms include reliving the event that was traumatic to the child, avoidance of anything that could remind the child of the trauma that occurred, and hyperarousal (Levy & Orlans, 1998). Traumatized children may continue to have intense memories and associated feelings related to the trauma that they attempt to control through the avoidance of displaying any type of affect that could trigger and intensify the memory (Lowenthal, 1999). These children also tend to avoid

any reminders of the trauma and perceived threat through impulsive behaviors and other responses (Kagan, 2004).

Social (Relationships). Trauma such as emotional neglect can have devastating long and short-term effects on children's abilities to successfully interact with family, peers, and teachers (Levy & Orlans, 1998). Insecure relationships based on mistrust and inconsistency cause impairments not only in children's personal development but also how children relate to other people (Peluso, et al., 2004). Children who were physically or sexually abused may avoid closeness and intimacy with others because that closeness puts them in a position of vulnerability and represents threat rather than love (Lowenthal, 1999). Children with abusive and/or neglectful histories have difficulty interacting with others in social contexts. They tend to be withdrawn and passive, although aggression and disciplinary concerns in the school environment can occur (Perry, et al., 2002).

Cognitive Structure (negative internal working model). As addressed earlier, internal working models are children's mental representation of how they sees themselves, others, and the world. Daily interactions with others continually shape and validate what children knows to be true about themselves and others, as well as if the world can be perceived as a safe place or not. Negative messages given to children over time will become an ingrained part of how they view themselves (Levy & Orlans, 1998). Within an abusive, neglectful, and otherwise traumatic environment, children begin to lose trust as well as a sense of safety and security (Becker-Weidman, 2003b). As a result, children develop a negative working model that serves to represent how they perceive themselves, others, and their environment (Levy & Orlans, 1998). These internal representations are extremely difficult to alter because they operate at a deeply rooted

unconscious level that serves as the foundation from which children see the world. This "blueprint" becomes a dramatic influence on children (Delaney, 1998). Children believe that they have no real influence on the world around them, learn to rely on themselves because others can't be trusted, and feel shameful, unworthy, and unlovable due to the internalization of negative messages received from others (Becker-Weidman, 2003b; Delaney, 1998; Levy & Orlans, 1998; National Abandoned Infant Assistance Resource Center (NAIARC), 1999). The negative mental representation that children have of caregivers and other adults is that they are inconsistent, hurtful, threatening, and that they can not be trusted for support (Becker-Weidman, 2003b). Furthermore, since children feel that their caregivers are inattentive and unresponsive to their needs, children will have a strong tendency to misbehave in an attempt to gain attention (Delaney, 1998). The negative worldview that children have, as shaped by their internal working model, includes cynical, overanxious views that that the world is threatening, hostile, and overwhelmingly chaotic and unpredictable (Delaney, 1998; Levy & Orlans, 1998; NAIARC, 1999).

Trauma and risk factors in a child's life significantly impact how a child develops. Breaks in the attachment cycle and profound deficiencies in meeting the fundamental needs of children are the results of trauma, parent and child risk factors, and neglect. In turn, trauma results in many developmental deficits and maladaptive responses that can impact how a child forms healthy relationships and attachments. The next section draws specific attention to how the bonding cycle is broken as a result of trauma and unhealthy development.

Broken Bonding Cycle

Having recognized that infants have significant responses to attachment disruption, the 'protest-despair-detachment' cycle was developed by researchers as a way to identify the stages that infants go through when their needs are not met (Ainsworth, et. al, 1978, cited in Delaney, 1998; Bowlby, 1973). When infants have a significant need, they will *protest* by showing signs of distress such as crying and temper tantruming, as well as actively attempting to seek out their caregiver. If unsuccessful, infants will show signs of *despair* and depression as they quietly withdraw and become inconsolable even when strangers attempt to alleviate their stress and fulfill their need. At the time of reunion with the primary caregiver, infants will display signs of *detachment* towards the caregiver. Infants will seem to be disinterested and actively avoid the caregiver.

Unresponsive infants set in motion another destructive cycle that undermines healthy attachment development (Cline, 1992, cited in Levy & Orlans, 1998). When infants are unresponsive and resistant to caregiver's attempts at loving attention, caregivers may get anxious and insecure about their own caregiving abilities. As a result of these anxious feelings, caregivers may withdraw from the infants and the infants will pick up on the caregiver's increased stress and anxiety. The infants themselves will become anxious and fearful and thus increase their perceptions that their caregiver is unsafe and unpredictable (Cline, 1992, cited in Levy & Orlans, 1998).

In contrast to the healthy bonding cycle in which a child's needs are sufficiently met, a child who experiences early trauma such as abuse, neglect, violence or separation will not have the consistency necessary for adequate bonding to occur and trust to develop (Chapman, 2002). When an available caregiver does not consistently meet an

infant's needs, the infant will become mistrusting towards others and learn that adults will not be there to take care of him. The infant therefore has to learn to take care of himself and be in control of his immediate environment (Evergreen, n.d.; Keck & Kupecky, 2002; Wilson, 2001). Simply stated, if an infant's needs are not consistently met in a caring, predictable manner, attachment will not develop normally (Becker-Weidman, n.d.)

This section addressed types of trauma as well as parent and child risk factors that increase a child's susceptibility to developing attachment problems. Also addressed were the developmental deficiencies that result from trauma and how the bonding cycle can be significantly damaged when children are exposed to trauma. In the following section, the specific disorder that can develop as a result of insufficient attachment development will be discussed.

Reactive Attachment Disorder

Definition

According to the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition Revised (2000), Reactive Attachment Disorder (RAD) of Infancy or Early Childhood is defined as "markedly disturbed and developmentally inappropriate social relatedness in most contexts that begins before age 5 years and is associated with grossly pathological care" (DSM-IV, 2000, p. 127). Children can display one of two types of RAD: inhibited or disinhibited. For children with *inhibited* type, the distinguished feature is that of the "persistent failure to initiate and to respond to most social interactions in a developmentally appropriate way" (p. 127). For example, children may avoid or be resistant to attempts at being comforted, as well as be withdrawn and

unresponsive to caregivers (Cleveland, 2002). Children who display *disinhibited* RAD present problems in social relatedness through "indiscriminate sociability or a lack of selectivity in the choice of attachment figures" (DSM-IV, 2000, p. 128). Children who exhibit this type of attachment disorder tend to be show inappropriate familiarity with strangers as well as the inability to be appropriately selective in their choice of attachment figures (Cleveland, 2002).

Children with Reactive Attachment Disorder (RAD) do not form emotionally healthy relationships with their primary caregivers and are socially impaired (Cleveland, 2002; Wilson, 2001). Children who are most at risk for developing RAD are children who have experienced excessive abuse and neglect early in life as well as extremely negligent care (Cleveland, 2002; Wilder, n.d.). It is important to note that a childhood characterized by trauma doesn't necessarily mean that a child will develop an attachment disorder, the risk is higher (Sheperis, et al., 2003).

Symptomology

When considering the vast array of RAD symptoms, an underlying theme is that children are extremely mistrusting of others. Through early traumas such as abuse and severe neglect, children learn that they are the only ones that can be relied on to take care of themselves and they will go to great lengths to make sure that other people don't attempt to get too emotionally invested in them (Feinberg, n.d.). The following symptoms of reactive attachment disorder are explored in terms of behavioral, cognitive, emotional, social/relationships, physical, and moral/spiritual aspects of the child.

Behavior. The behavioral indicators of RAD are symbols of the children's need to protect and defend themselves because they have come to believe that the world will not

protect them. When others get too emotionally close to them, they pull away and do things that they believe would keep others away. The pain of loss, separation, and instability is too great to go through again, and the children's only defense is to push others away first. Power and control are important to children with RAD, because those are the things that they felt had been taken away from them. By pushing others away, or displaying indiscriminate affection towards mere strangers, children act as though to say: "*I am in control of who I talk to and who I get close to. You can't leave me because I left you first*". At the core of behavioral conduct problems in children with RAD is the negative working model that forms the foundation for how children see themselves, others, and the world (Delaney, 1998). These behaviors serve an important purpose for children in that they work to obtain attention from the caregiver and, in contradiction, also serve to keep the parent at a distance. If children are feeling unwanted and worthless, they will strive for the attention that they crave (even though it is negative), yet at the same time sabotage any potential for close relationships. This closeness presents a threat to the children's internal working model and emotional vulnerability. The children's behavior can be extremely confusing and contradictory as they try to keep caregivers close and distant at the same time, sending caregivers mixed messages regarding the child's true intent towards them (Delaney, 1998).

There are many antisocial and outwardly aggressive behaviors that are commonly displayed by children with RAD (Delaney, 1998; Evergreen, n.d.; Keck & Kupecky, 2002; Levy & Orlans, 1998). These conduct problems have been grouped into several categories: sadism and violence, disordered eating, counterfeit emotionality, kleptomania/compulsive lying, sexual obsession/compulsion, passive-aggressiveness, and

defective conscious (Delaney, 1998). Many of these oppositional and defiant behaviors can also be self-destructive and include such things as self-mutilation or possible attempts at suicide (Evergreen, n.d.; Levy & Orlans, 1998). These behaviors can also be threatening to others, as children with RAD have a tendency to victimize others through bullying, violence, or sexual perpetration towards others (Levy & Orlans, 1998).

Some researchers have noted that these behaviors serve: 1) to increase the caregiver's interaction with the child (even though the interaction could be punitive in nature) (Speltz, 1990, cited in Delaney, 1998), 2) to try and keep the caregiver emotionally and physically distant and, 3) as an outlet to vent frustration and anger that has been building up inside (Delaney, 1998).

Cognition. As mentioned in earlier sections, children who experience breaks in the attachment process due to trauma will develop a negative internal working model that sets the standard for how they see themselves, others, and the world. Children with RAD see their caregivers as dangerous and unavailable and see the world as unsafe (Sheperis, et al., 2003). The behaviors that these children exhibit stem from this unconscious working model that is difficult to modify. Certain therapeutic approaches work to modify children's negative belief systems that will, in turn, affect their outward behavior.

Affect. One of the most prevalent symptoms of RAD that permeates through the child's development and wellbeing is the inability to appropriately modulate and display emotion. As a result, most of the child's emotional energy is displayed through intense rage and anger fueled by fear and shame (Delaney, 1998; Levy & Orlans, 1998; Sheperis, et al., 2003).

Children learn how to regulate their emotions through the examples set for them by their caretakers. If the caretaker is negligent or unavailable, children will not be able to modulate their own emotions nor recognize feelings in others and develop empathy. If children fear the caregiver or have developed a negative expectation that the caregiver will not be available, they will be unable to accurately and appropriately express their feelings and thoughts. Since this important part of development is not being nurtured, children with attachment disorders will have an extremely difficult time learning how to express themselves appropriately and effectively (Delaney, 1998). When children lack empathy they are not able to understand what others feel and can not see how their actions affect other people (Perry, 2000b). Because of this lack of understanding and empathy, children with attachment disorder will act out aggressively and without remorse (Perry, 2000b). The emotional core of the acting out behaviors are feelings of shame, anger, depression, hopelessness, anxiousness, and irritability brought on by years of abuse and neglect that have fostered the children's development of negative beliefs about themselves, others, and the safety of the world around them (Evergreen, n.d.; Levy & Orlans, 1998). If children with attachment disorders decide to display affection, they will go to great lengths to make sure that the affection is given on their terms only, even if it is inappropriate and especially if it is in front of other people for the purpose of soliciting a reaction (Levy & Orlans, 1998; Sheperis, et al., 2003).

Socialization/Family Relationships. A hallmark characteristic of children with RAD is superficial charm and a false sense of relationship-building. On the surface, these children appear as though there is some connection being made between themselves and others when in fact the behaviors are manipulative and superficial (Sheperis, et al.,

2003). Children with RAD may intentionally put themselves in positions in which they are victimized as well as being the one victimizing others. The basis for these maladaptive social relationships comes from the child's negative internal working model that views relationships as naturally threatening and affectionless (Levy & Orlans, 1998; Sheperis, et al., 2003). Children with reactive attachment disorder have extreme difficulty dealing with authority, especially when limits are imposed on them and they don't have control. As a result, these children choose aggression, hostility, and defiance as the primary means of interacting with authority figures (Levy & Orlans, 1998). Although children with RAD tend to have unstable, superficial relationships with their peers, they may in fact gravitate towards their peers as primary relationships because they don't want to risk the rejection and hurt they've experienced from adults (Kagan, 2004; Levy & Orlans, 1998). Conflict, disrespect, and other violent outbursts are common ways that children with RAD communicate because they have not learned more effective ways and also because they have observed the behavior in caregivers (Kagan, 2004).

Physical. Because children with RAD have excessive feelings of anger, frustration, fear, and sadness, and are unable to effectively express them in appropriate ways, these intense feelings stay within the child and tend to cause many physical disturbances (Levy & Orlans, 1998). Rigidity, tension, and physical defensiveness are common physical symptoms in children with RAD. Over-reacting to minor physical injuries, yet appearing to be virtually desensitized to considerable physical trauma and displaying a high pain tolerance, are common reactions in children with RAD (Levy & Orlans, 1998; Sheperis, et al., 2003). Children may also display very poor hygiene,

possibly using that as a defense so people remain physically distant (Sheperis, et al., 2003).

Moral/Spiritual. Since children with attachment problems have a skewed sense of who they are and how they fit into the world, it will be very difficult to be able to obtain the positive sense of wellbeing about themselves and the security of the world around them that helps to foster spiritual health (Hafen, Karren, Frandsen, & Smith, 1996, cited in Levy & Orlans, 1998). Spirituality involves a deep, trusting relationship with oneself and others; that very core is significantly deficient in children with attachment problems. Because of not being able to feel fully connected with other people, a lack of remorse and conscience is common in children with RAD because they don't really feel fully invested in others and in themselves (Levy & Orlans, 1998).

Differential Diagnoses

Since RAD has such outwardly behavioral characteristics, it is easy for many parents, teachers, and other professionals to classify children with this disorder as defiant, oppositional or moody. RAD often goes undiagnosed because the symptoms are varied and confusing. Mental health counselors need to be fully aware of not only the symptomatic behaviors, but the developmental history of the child as well (Becker-Weidman, n.d.; Sheperis, et al., 2003). At the core of the visible behaviors expressed by children with RAD is the pain of early experiences that have damaged a child's ability to develop healthy connections with others. During development, a child's level of trust in the world and with other individuals has diminished, and the child's cognitive structure has been distorted.

When considering a diagnosis of Reactive Attachment Disorder there are a variety of alternate diagnoses that need to be ruled out. Due to the significant social impairments that children with RAD display, a possible diagnosis of pervasive developmental disorders such as autism or Asperger's disorder should be considered. Significant social delays are exhibited in children with any of the PDD disorders (Boykin & Jensen, 2004; Sheperis, et al., 2003).

Diagnoses of Oppositional Defiant Disorder and Conduct Disorder describe the overt, behavioral symptoms that most children with RAD display (Becker-Weidman, n.d.; Sheperis, et al., 2003). By not exploring the underlying causes for the behaviors, opportunities for significant therapeutic growth can be missed and a child with a more accurate diagnosis of Reactive Attachment Disorder may not receive the treatment that they need (Sheperis, et al., 2003).

Impulsive behaviors and a lack of cause and effect thinking, in addition to other symptoms, could warrant a diagnosis of Attention Deficit-Hyperactivity Disorder (Becker-Weidman, n.d.; Boykin & Jensen, 2004; Sheperis, et al., 2003). When children have experienced significant trauma early in life, the brainstem and midbrain functions are overdeveloped and aroused in such a way that children live in a constant state of anticipated threat and/or fear. As a result, children may react impulsively and show significant motor hyperactivity (Brien, n.d.). Many children with RAD present with a secondary diagnosis of ADHD (Becker-Weidman, n.d.). The correlation of ADHD and RAD is around 40% to 70% of children who have been abused and/or neglected (Levy & Orlans, 1998)

Post-Traumatic Stress Disorder and Depression are diagnoses commonly considered for children with Reactive Attachment Disorder (Becker-Weidman, n.d.). Most, if not all, children with attachment difficulties have experienced some sort of traumatic event (or events) in their lives that have prevented them from being able to trust others and form healthy relationships. Avoidance of particular reminders of the trauma and the lack of interest in activities may signify PTSD or depression (Becker-Weidman, n.d.; Rosenstein & Horowitz, 1996).

If attachment-related difficulties go untreated into adolescence and adulthood, the chances are greater for advanced psychopathogy (Boykin & Jensen, 2004). Various Axis II personality disorders such as borderline, narcissistic, histrionic, and antisocial may emerge as a child gets older. As with any other differential diagnosis process, it is important to look at the big picture and explore the child's behaviors, background, physical health, and any other factors that could help create the most accurate diagnosis possible as well as prevent disorders into adulthood.

Intergenerational Transmission

A vicious cycle can be perpetuated through generations of abuse and neglect. If parents did not receive proper love, care, and affection as children, they will have a difficult time showing that type of nurturance towards their own children. While the parenting ability may be there, parents may be painfully reminded of their own childhood as they see their children exhibit attachment-seeking behaviors. As a result, these parents may become paralyzed and unable to respond back to their children in a loving, caring way (Kagan, 2004). DeLozier (1982) proposed and validated that parents who are abusive and neglectful towards their children reflect the inadequate development of

attachment throughout their own lives. If a parent responds to parent-child separation with anxiety, anger and increased attachment need, these feelings have a tendency to permeate to the child, thus inhibiting the child's self-reliance and exploration.

RAD is complicated and difficult to understand due to the intricacies of the symptoms, the environmental influences that affect each child, and the similarities to other disorders. The following section discusses several specific treatment approaches that can be utilized by mental health professionals working with children with Reactive Attachment Disorder.

Treatment of Attachment Disorder

Fundamental Characteristics of Treatment

Children with attachment disorder may not benefit from traditional therapies like talk therapy or play therapy because the treatment is based on trust between the therapist and child, and trust is what is significantly impaired within the child (Reber, 1996; cited in Wilson, 2001). These children do not trust others. Some therapists believe that traditional therapies are only beneficial once the child has worked with a therapist trained in childhood attachment disorder who knows how to work with the child to decrease anger and rage, and then to rebuild trust (Thomas, n.d.).

While there are many different treatment approaches to be considered when working with a child with an attachment disorder, there are several common themes that run throughout each of the unique approaches. For most attachment-based therapies, the goal is to help the child re-establish and rebuild attachments with caregivers while maintaining a safe, supportive environment for the child (Becker-Weidman, n.d.;

Cleveland, 2002). Reestablishing the bonding cycle that was severely broken early in life is an important characteristic in attachment-based therapies (Keck & Kupecky, 2002).

Another important characteristic of attachment therapy is the active involvement of not only the child, but the family support network as a whole (Attachment Center, 1997, cited in Wilson, 2001; Hanson & Spratt, 2000, cited in Sheperis et al.,2003; Kagan, 2004). Also, keeping treatment as directly related to the specific problems that the child and family are experiencing will maximize the effectiveness of the treatment, resulting in more successful resolutions (Keck & Kupecky, 2002).

Some other fundamental characteristics of attachment therapies have to do with how the therapist interacts with the child, including high energy, close physical proximity, continual stimulation and frequent, consistent eye contact and attentiveness (Keck & Kupecky, 2002).

Role of Parent/Caregiver in Treatment Process

For treatment to be successful, active involvement of the parent and/or caregiver, continually maintained within the home, is crucial during the therapeutic process. According to Thomas (n.d.), the mother is the significant figure involved in therapy with the child because the mother/child bond is what generally needs healing. This differs from more traditional therapies that build trust between the child and the therapist. Parents and/or other caregivers need to be educated about their child's attachment difficulties, supported through the process of rebuilding attachments, and also be provided their own therapeutic support as they deal with the challenges of working with a child with an attachment disorder (Cleveland, 2002; Delaney, 1998; Keck & Kupecky, 2002; Perry, 2000b). Parents need to feel supported throughout the difficult process of

building a relationship with a child with attachment difficulties and they need validation and encouragement that their efforts are appreciated and helpful even though the results may be slow to form (Keck & Kupecky, 2002).

Therapists can provide parenting skills that help to facilitate attachment (Cleveland, 2002). Learning how to effectively implement consequences and punishments can reduce the problematic behavior while still maintaining a positive relationship between the parent and child. In addition, teaching parents how to listen to and talk with their children, as well as how to be consistent and predictable are skills that parents can use to enhance their parenting abilities. Finally, teaching the parents how to take care of themselves and how to take advantage of any available resources can continue to strengthen parents' abilities to manage a child with RAD.

Actively involving the parent in the treatment process is also important because it helps promote the building of a strong, trusting relationship between the parent and child; the therapist can be used as an educator and facilitator of this process within a safe environment (Cleveland, 2002). Open communication between the therapist and parent regarding the progress or regression of the child is very important (Delaney, 1998).

Role of Therapist in Treatment Process

The role of a mental health counselor working with an attachment-disordered child and his/her family can be challenging and confusing. The role of the therapist is to ultimately help foster healthy, attached relationships between children and their caregivers, but there are some unique challenges along the way. While the therapist should develop a healthy rapport and therapeutic relationship with the child, a child may develop a 'pseudo-attachment' towards the therapist, as that relationship may appear to

be less threatening than forming a relationship with their actual parent or caregiver (Delaney, 1998). It is important that the therapist is aware of this possible relationship formation, as it could hinder the goal of child-parent attachment.

One of the major goals of an effective attachment therapist is to be able to break through to the child's inner emotionality to a point where the child can honestly share their feelings (Thomas, n.d.). In addition, a therapist must be able to listen to the child's behaviors and see beyond what is occurring in the office; the child may be manipulative and cunning during the session and an effective therapist needs to be aware of this (Thomas, n.d.).

Another important role of the therapist is to be extremely knowledgeable about reactive attachment disorder and all of the intricacies that are involved with making an accurate diagnosis. Having a clear understanding of family and developmental history is important for understanding not only the children, but the environment from which they come from (Becker-Weidman, n.d.; Sheperis, et al., 2003). Having knowledge of the behaviors of attachment-disordered children as well as the cognitive and emotional undertones that guide the behaviors will help a therapist understand the child's motivations. This knowledge will help the therapist provide the most effective interventions possible (Becker-Weidman, n.d.).

In addition to these fundamental roles of therapists working with children with attachment disorders, each specific approach to therapy will vary and the therapist will be involved in different ways. The following section addresses several treatment approaches.

Five Specific Treatment Approaches

Corrective Attachment Therapy. One of the primary goals of corrective attachment therapy is to develop a healthy cognitive structure that challenges a child's current belief system, a belief system that was developed in the framework of abuse, neglect, or any other trauma that could lead to attachment difficulties (Levy & Orlans, 1998). Corrective attachment therapy is intended to imitate the aspects of a healthy, attached relationship between a parent and child, including physical, emotional, and interpersonal aspects of the relationship (Levy & Orlans, 1998). Some of the fundamental needs of a child, in addition to various other important characteristics, must be present in the therapist/child relationship with the goal of a re-established parent/child relationship. These characteristics include: structure, attunement, empathy, positive affect, support, reciprocity, and love (Levy & Orlans, 1998).

Using the three stages of revisiting the trauma, revising the trauma, and revitalizing the child, one of the main characteristics is that the therapy is change and goal oriented, as well as flexible and open to change as treatment progresses (Levy & Orlans, 1998). At each of the three stages the therapist does a thorough assessment, helps to create goals, uses therapeutic methods to achieve the goals, and then ends up by reassessing the progress so far. In general, holding therapy is used to dissipate rage in a safe environment so the child can learn not only how to manage intense feeling but to build trust and security in others. The 'holding nurturing process' or HNP, is used by proponents of corrective attachment therapy (Levy & Orlans, 1998). Children are comfortably held by the parent or caregiver in such a way that the children can not get out of the embrace. This approach is not without its critics, however. To some therapists,

holding therapy is considered dangerous and unethical, yet to the proponents of this treatment, holding is the best way to recreate the bonding behaviors and attachments that never occurred during infancy and early childhood.

Narrative Therapy. Narrative therapy embraces the idea that if people who have had traumatic pasts can tell and re-tell the story of their lives, they will be able to shape new realities and come to new understandings of their lives. This fundamental background can be applied to children and reframed as 'storytelling', helping the child to reframe their life experiences and ultimately work to shift the child's negative internal working model to a more positive outlook (Boykin & Jensen, 2004; Kagan, 2004). A narrative approach does not negate or deny the traumatic past of the child, rather it helps with healing the past and creating a new reality from which to base the child's life. Externalizing the problem from the child and reframing the problem as something to be solved allows the child freedom from his past and empowers them to come up with solutions and possibilities to combat the problematic past and have a more positive future (Kagan, 2004). What is interesting about this approach to therapy with attachment-disordered children is that the overt problematic behaviors are not necessarily addressed, as most of the focus is on the motivation towards these behavior problems (Boykin & Jensen, 2004).

Many children who have experienced significant trauma early in their lives may find the trauma too difficult or painful to recount for the purpose of telling their life story; they may need extra support and guidance from parents and therapists to emerge out of shame and into a more strength-based internal working model (Kagan, 2004). According to trauma-based narrative work, it is important that the child knows what happened in his

life and that parents/caregivers do not minimize the traumatic events. Remaining honest about the child's experiences helps because keeping things secret from the child intensifies his fear that something too painful to even talk about has occurred. A key focus to keep in mind is that the message needs to be sent to the child that they are inherently good and the past traumas are based on choices that adults have made (van Gulden & Bartels-Rabb, 1993).

Four specific narrative outlines have been provided as a guide to working with attachment-disordered children in therapy. The *claiming* narrative is generally written or told in the first person and works to solidify the fact that the child deserved nurturance and love unconditionally from family. Remembering family history and tradition fosters a sense of belonging and the goal is to enhance attachment to parents (Boykin & Jensen, 2004). The *developmental* narrative recalls how the child progressed through the developmental stages, leading all the way up to the present. The *trauma* narrative, told in the third person, sheds light on the history of the trauma in an honest way and children use this to regain some control as well as understanding of the significance of the trauma in their lives. The goal of this narrative is to enhance growth and healing. The final narrative, the *successful child,* helps tell a story that teaches children how to display healthy, positive behaviors in their daily lives. The overall message from narrative therapy empowers traumatized children to recognize their past, reframe, and emerge with the ability to trust and form healthy relationships.

Dyadic Developmental Psychotherapy (DDP). Some authorities assert that dyadic developmental therapy is the only effective treatment for children with attachment disorders that is supported through published research in peer-reviewed journals

(Myeroff, Mertlich, & Gross, 1999, cited in Becker-Weidman, 2003b). DDP is a therapeutic approach that helps children heal from past trauma and resolve dysfunctional attachment by experiencing safety and affective attunement with their caregivers (Becker-Weidman, 2003b; Boykin & Jensen, 2004). An affectively attuned relationship between two individuals is when they experience the same affect and, within the safety of this relationship, the trauma that was experienced in the past can be safely and securely explored (Becker-Weidman, 2003b). The purpose of this therapy is to try and rebuild the dyadic regulation process that is supposed to naturally occur between parent and child during infancy however, due to trauma, this process has been severely hindered (Becker-Weidman, 2003b).

This family-focused treatment has three main parts: educate parents, teach parenting skills, and intense emotional work with the child (Becker-Weidman, 2003b; Boykin & Jensen, 2004). In addition, this treatment is centered on five core principles from which to structure the therapy (Becker-Weidman, 2003b). The first principal is that the therapy must be *experiential*, meaning that the child must have healing, soothing experiences during therapy rather than having 'words' as the main therapeutic tool. According to Becker-Weidman, the experiences that a child should have in therapy need to help the child feel safe, secure, accepted, empathic and emotionally attuned to others. Known as PACE, a child's emotional attunement can be nurtured by being Playful, Accepting, Curious, and Empathic. The second principal of dyadic developmental psychotherapy is that it is *family focused.* Parents are extremely active in the treatment process, as they work to create loving, safe, healing environment for the child. Unconditional love and empathy are important for the parent to display towards the child

during this healing process. The third principal is that, in therapy, *the trauma must be directly addressed* (Becker-Weidman, 2003b). As in narrative therapy, addressing the past trauma is an important step towards healing and revising children's overall worldview and narrative of their lives. Revisiting past traumas in a safe environment through narratives and psychodramas encourages children to integrate their past experiences with their current thoughts, feelings and behaviors. The fourth principal of dyadic developmental psychotherapy is that a *safe and secure environment* should be created for the child and be consistent within the home, school, and therapeutic environment (Becker-Weidman, 2003b). The fifth principal of dyadic developmental psychotherapy is that the *therapy is consensual* and *does not involve physical restraints* (Becker-Weidman, 2003b). It is important that a child does not feel coerced or threatened within the therapeutic environment, as it may hinder the sense of trust and safety that a child with attachment problems needs to experience.

Cognitive-Behavioral Interventions. Working at a child's cognitive level is an important approach to assume, as this intervention helps to restore a child's inner thought processes that have been shaped by an unhealthy environment. It may be tempting to focus on the child's behavioral disturbances but it is important to realize that many of the outward behaviors displayed are the result of cognitive errors due to early traumatic experiences. A cognitive-behavioral approach to therapy takes an important look at how thoughts, feelings, and behaviors are intertwined. A three-phase cognitive-behavioral approach starting with the identification of children's cognitive errors and distortions, then moves to an assessment of these distortions, and then ends with replacing the

cognitive distortions to more reality-based cognitions (Cohen, Mannarino, Berliner, & Deblinger, 2000, cited in Sheperis, et al., 2003).

TheraPlay. Theraplay is an engaging treatment approach that fosters healthy interactions with others, enhances self-esteem, helps to build trust in others, and conveys a sense of belonging and security for the child (Chaddock, n.d.; Schafer, n.d.). Developed in the late 1960's by Ann Jernberg and her colleagues at the Theraplay Institute in Chicago, this treatment approach can be used with children who have severe emotional and behavioral problems due to biological deficiencies or who have had little success forming meaningful attachments and relationships with others (TheraPlace, n.d.). This play approach is modeled on the basics of healthy parent-child interactions and is divided into four main intervention areas: *structure* that promotes the building of trust and security for the child, *challenging* the child to take risks and increase self-esteem and personal confidence, *stimulation/engagement* during the therapy session that keeps the child active and aware, and *nurturance* that helps show the child that the world is a safe, caring, comforting place (Schafer, n.d.). TheraPlay can be done in a group setting or in a family setting (family members are generally involved throughout the entire process) and the driving belief is that change occurs through the development and maintainance of healthy relationships (Schafer,n.d.; Theraplace, n.d.). The intense, active, and physical theraplay sessions promote positive interactions within a safe, social environment (Schafer, n.d.).

Summary

This chapter addressed a variety of topics related to attachment development, childhood trauma, and treatment considerations. By first looking at a child's normal

stages of growth and attachment development, as well as a concise history and description of attachment theory, the chapter set the stage for further exploration into how childhood trauma influences normal development and attachment processes. As the chapter unfolded, it became apparent that significant childhood trauma such as abuse, neglect, violence, or separation impairs a child's ability to form healthy attachments, therefore negatively influencing healthy childhood development. The first few years of life are critical for bonding to occur and attachment to develop because of the dramatic influence this early experience has on nearly every area of a child's development. When traumatic events early in life impede a child's ability to form attachments with others, the child's reality of himself, others, and the world around him are negatively skewed and reflect an unsafe, untrusting framework for the child. Several treatment options, although varied in the specific approaches, share a common bond of trying to undo the child's negative working model as well as creating a safe, non-threatening environment from which the child can explore the past trauma and move towards healing and a more promising reality of themselves and others.

Chapter Three: Discussion

Introduction

Chapter Three includes a summary and a critical examination of the reviewed literature that is organized by revisiting the initial research questions proposed in Chapter One. Beginning with a concise summary of the literature findings, this chapter analyzes each research question by including both strengths and gaps in the existing literature. Following the review of each research question, recommendations for parents, mental health counselors, and other professionals are proposed.

Summary

Early attachment development significantly influences how people see themselves, how they view others and form relationships, and how they view the world in general. Therefore, it is safe to assume that early childhood experiences need to be nurturing and to foster a sense of security in order to form a solid foundation for healthy attachment development. Early experiences in life continually form and validate how children view themselves and others and, if the experiences are threatening, unpredictable and otherwise traumatic, most of the child's internal framework will be centered around this negativity.

The founder of attachment theory, John Bowlby (1988, 1969), collaborated with other researchers to develop the idea that attachment is not only rooted in genetics and serves to fulfill an infant's instinctual bond to be physically and emotionally close to a caregiver, but that the relational aspect of attachment is extremely important as well. Consistently viewed as a deeply enduring psychological connection between individuals, secure attachment provides security and protection during times of perceived or real

threat and stress (Bowlby, 1969; Evergreen, n.d.; Levy & Orlans, 1998; Perry, 2000a). This significant emotional relationship between two people, in this case between a parent and child, sets the tone for how the child will develop subsequent relationships (Bowlby, 1969; Perry, 2000a). On a larger scope, the quality of early relationships impact the child's physical, emotional, cognitive, social, and moral development or, in other words, the overall health and well-being of a child as they progress through life (Becker-Weidman, n.d.; Bowlby, 1969; Evergreen, n.d.; Karen, 1998).

As Bowlby (1969) continued to study and refine his theory of attachment, he divided the attachment process into the four distinct stages of preattachment, recognition/discrimination, active attachment, and partnership. Each stage represents a progression towards the goal of secure attachment development throughout early infancy. The common thread throughout each of the stages is the consistency that instills in young children that relationships equate to comfort, love, and stability (Wilson, 2001). The success of this healthy progression towards secure attachment requires that several fundamental needs are provided to the child, as well as healthy parent characteristics and parenting styles that can promote these particular needs. Structure, predictability, consistency, non-punitive limit-setting, and nurturance are five basic needs of children that must be present in order to insure healthy attachment development (Tylenda, 2004). The presence of these needs during childhood creates a healthy attachment base and therefore significantly influences a child's total development. Research has demonstrated that the absence of these core needs can result in disordered childhood development, including impaired attachment development.

Healthy parent characteristics and responses to the child are important for insuring healthy attachment development in children. Successful progression through the bonding cycle is a reciprocal process between the parent and child where the presence of fundamental need fulfillment are continually validated and strengthened as the cycle is repeated and attachment becomes strengthened (Levy & Orlans, 1998; Perry, 2000a). Expressing a need, displaying attachment-eliciting behaviors, having the need gratified, and ending with an increased development of trust is a cycle that has the potential to be repeated numerous times per day in a young infant (Becker-Weidman, n.d.; Feinberg, n.d.; Keck & Kupecky, 1995; Levy & Orlans, 1998; Perry, 2000a; Sheperis, et al, 2003). A parent must be fully attuned and emotionally aware of the infant's needs in order to be able to respond in an accurate, sensitive, and timely manner (Kagan, 2004; Perry, 2000a). Reading and responding to infant cues are important parenting characteristics that will continue to foster healthy attachment development as the bonding cycle validates the safety and security that infants seek from their parents. In addition to attunement, three other significant parental characteristics foster healthy attachments in children: responsiveness, sensitivity, and accessibility (Becker-Weidman, n.d.; 2002; Delaney, 1998). Furthermore, disciplining in a manner that doesn't threaten or disregard the parent/child attunement and bond is important in maintaining a sense of safety and security within the child that the relationship is still secure even when being punished (Kagan, 2004).

When provided with a nurturing, consistent environment, a child's ability to form secure attachment is strengthened. Ainsworth (1963; 1967) (cited in Bowlby, 1988), conducted research in Uganda and laboratory settings in the United States to study

attachment patterns. Many children are not raised in environments that foster healthy development, and varying attachment styles emerge. In Ainsworth's 'strange situation' experiments, the secure, insecure-avoidant, and insecure-ambivalent patterns were identified as a result of how infants responded to a parent leaving and returning (Ainsworth, et al, 1978, Main & Hesse, 1990; both cited in Delaney, 1998). The two insecure patterns results from an infant's lack of confidence that the parent will return or respond in a predictable manner. Later, a fourth pattern of attachment, disorganized/disoriented, was identified because other researchers realized that not all infants fit exactly into the previous three attachment types (Main & Solomon 1986, cited in Wilson, 2001). These infants displayed incoherent reaction patterns to separations and reunions with their primary caregivers and is generally seen in infants and children who have experienced severe trauma during critical times of attachment development (Delaney, 1998; Main & Solomon, 1986, cited in Wilson, 2001).

A child who experiences significant trauma early in life lives in a world of chaos and unpredictability in which fear and anxiety are prevalent. The fundamental needs are not sufficiently met when trauma as abuse and neglect take the place of love and security. The person that an infant or child should feel the most comfort from most often is the same person eliciting feelings of fear, anxiety, and mistrust (Boykin & Jensen, 2004). Research indicates that when caregivers traumatize a child, the child's internal cognitive model of how the child sees himself, others, and the world is negatively skewed and resistant to change, resulting in an extreme lack of trust in others and a hesitancy towards forming relationships (Becker-Weidman, 2003; Delaney, 1998; Levy & Orlans, 1998; Lowenthal, 1999). Traumas such as physical and sexual abuse, neglect, violence, and

separations generally involve impairments in the parent-child relationship, thus inhibiting the fundamental needs that are necessary for successful attachment development.

There are various parent and child risk factors that can contribute to insecure attachment development. Parents' lack of emotional availability and display of harsh, critical responses towards the child contribute to emotional neglect and/or abuse and therefore inhibits children to develop safe, intimate relationships with others (Boykin & Jensen, 2004; Keck & Kupecky, 2002; Perry, 2000; Rosenstein & Horowitz, 1996). Pathogenic care due to mental or physical limitations, ignorance, or overwhelming distractions significantly impact parents' abilities to be fully present and attentive to their children (Boykin & Jensen, 2004; DeLozier, 1982; Keck & Kupecky, 2002; Perry, 2000). Just as parents can influence the attachment relationship, so can children. Irritable and unsoothing temperaments, significant medical conditions, and in utero drug/alcohol exposure can all influence the way children develop and, in turn, how they develop meaningful relationships with others (Levy & Orlans, 1998; Perry, 2000).

Significant trauma and contributing pathogenic parenting during critical periods of development create neurological, physical, emotional, behavioral, social, and cognitive deficiencies that inhibit proper childhood growth and development (Becker-Weidman, 2003; Delaney, 1998; Levy & Orlans, 1998; Monahon, 1993; Perry, et al., 2002). Children that live in threatening states of anxiety and fear have brains that overproduce stress hormones that keep children in a constant state of hypervigilance (Lowenthal, 1999). Physiologically, neglect influences the releasing pattern of growth-regulating hormones and physical development is compromised (Perry et al., 2002). Furthermore, the overproduction of stress hormones causes children to have difficulty regulating their

emotions and recognizing emotions in others (Becker-Weidman, 2003; Lowenthal, 1999). Aggressive sexual and violent behaviors directed towards others and bizarre self-soothing behaviors that emerge during times of high stress are overt, behavioral indicators of developmental disturbances that can inhibit relationship-building skills (Kagan, 2004; Levy & Orlans, 1998; Perry, 2000). A devastating effect of trauma is the extreme inability of children to interact in social settings and to trust others enough form close, intimate relationships (Lowenthal, 1999; Perry et al., 2002). Traumatized children's cognitive schema represents negative views of themselves, others, and the world and causes these children to rely on themselves because they believe others are not dependable and can not be trusted (Becker-Weidman, 2003b; Delaney, 1998; Levy & Orlans, 1998).

When infants' needs are not consistently met in a nurturing way, the bonding cycle that leads to secure attachment is disrupted and a cycle of protest-despair-detachment takes its place as infants make unsuccessful attempts at obtaining positive parent interaction (Ainsworth, 1978, cited in Delaney, 1998). Eventually, infants become unresponsive because they cannot predict when they will or will not be attended to; this pattern sets in motion another destructive cycle within the parents (Cline, 1992, cited in Levy & Orlans, 1998). The parents may become anxious and insecure about their parenting abilities and, in turn, continue to withdraw from their infants.

Significant trauma such as abuse and neglect, and the subsequent developmental problems that result, increase children's susceptibility to developing an attachment disorder. Reactive Attachment Disorder (RAD) is a disorder that impacts children's social relatedness in inhibited or disinhibited ways (DSM-IV, 2000). Children with

inhibited type fail to respond appropriately in social situations, if they even respond at all. However, children who display disinhibited type show indiscriminate affection towards anyone, therefore not showing preference towards any particular attachment figure. Although the exact diagnosis of RAD is somewhat uncommon, children most at risk for developing RAD are those who have been severely and consistently abused and/or neglected during critical development periods (Cleveland, 2002). Symptoms of RAD relate to children's negative cognitive schema that people are mistrusting and the world is a dangerous place (Delaney, 1998).

Behavioral, cognitive, emotional, social, physical, and moral characteristics of children are significantly impacted as a result of maladaptive attachment behaviors. Tendencies towards aggressive and antisocial behaviors are commonly displayed in children with RAD and these conduct problems serve to keep others at bay, maintain or increase positive or negative caregiver interaction, or to vent built up frustration and anger (Delaney, 1998; Evergreen, n.d.; Keck & Kupecky, 2002; Levy & Orlans, 1998; Speltz, 1990, cited in Delaney, 1998). The negative internal working model serves as a base from which these behaviors occur, and this cognitive model is difficult to modify (Sheperis, et al., 2003). The emotional core of the overt behaviors are feelings of shame, anger, depression, hopelessness, anxiousness, and irritability that developed as a result of early traumatic experiences such as abuse or neglect (Evergreen, n.d.; Levy & Orlans, 1998). Furthermore, appropriate affect expression and regulation remains difficult for children with RAD because of poor role modeling and fear of the caregiver (Delaney, 1998). Pent up frustration and other intense feelings effect children's physical development because of the symptoms of rigidity, tension, and physical defensiveness

(Levy & Orlans, 1998; Sheperis, et al., 2003). Superficial charm towards others and difficulty with authority figures as shown through conflict, disrespect, and violent outbursts are two hallmark characteristics of social impairment in children with RAD (Kagan, 2004; Levy & Orlans, 1998). Since children with RAD have difficulty showing empathy and feeling connected to people, lack of remorse and conscience are common responses (Levy & Orlans, 1998).

Reactive Attachment Disorder shares similar characteristics to several other disorders described in the DSM-IV-TR. The intricacy and variety of RAD symptoms makes this disorder difficult to accurately diagnose (Becker-Weidman, n.d.; Sheperis, et al., 2003). Exploring the core of the overt behavioral symptoms helps to get at the deeper issues that deserve therapeutic attention. Pervasive Developmental Disorders, Oppositional Defiant Disorder, Conduct Disorder, Attention Deficit-Hyperactivity Disorder, Post-Traumatic Stress Disorder, Depression and various Axis II personality disorders should be considered and ruled out before making a diagnosis of Reactive Attachment Disorder (Becker-Weidman, n.d.; Boykin & Jensen, 2004; Levy & Orlans, 1998; Rosenstein & Horowitz, 1996; Sheperis, et al., 2003).

When considering treatment approaches for children with Reactive Attachment Disorder, it is important to note that traditional therapies may not be effective in meeting the therapeutic goal of repairing and reestablishing attached relationships with others because of the children's difficulty in building rapport and inability to develop trust in others (Cleveland, 2002; Reber, 1996, cited in Wilson, 2001). Important attachment therapy characteristics include the reestablishment of the bonding cycle, the active involvement of the child and family network, and keeping the treatment directly related

to the specific problems the child and family are experiencing (Attachment Center, 1997, cited in Wilson, 2001; Hanson & Spratt, 2000, cited in Sheperis, et al., 2003; Keck & Kupecky, 2002). Supporting parents and strongly encouraging their active involvement in the therapeutic process is crucial to successful therapy outcomes for children with attachment difficulties (Cleveland, 2002; Delaney, 1998; Keck & Kupecky, 2002; Perry, 2000b). The role of the therapist is to help attachment-disordered children rebuild relationships and trust with their parents or caregivers while remaining aware that these children may attempt to direct their efforts towards forming a less threatening relationship with the therapist (Delaney, 1998). Being knowledgeable of the signs, symptoms, and differential diagnoses of RAD is important for therapists as well (Becker-Weidman, n.d.; Sheperis, et al., 2003).

There are many different therapeutic approaches that can be used when working with children with attachment difficulties. Corrective Attachment Therapy, narrative therapy, Dyadic Developmental Psychotherapy, cognitive behavioral interventions, and a form of play therapy known as TheraPlay are just several approaches mentioned that have shown therapeutic gains in children with RAD (Boykin & Jensen, 2004; Evergreen, n.d.; Kagan, 2004; Myeroff, Mertlich, & Gross, cited in Becker-Weidman, 2003b).

Critical Analysis

A critical analysis of the literature on attachment disorder and childhood trauma will be guided by addressing each of the initial research questions.

1. *What role do parents and caregivers play in the development of both healthy and unhealthy attachment formation in children?*

Research has strongly indicated that children's parents or other primary caregivers play an extremely critical role in how children learn and develop attachment. This influence can be the result of intergenerational transmission, meaning that if parents were abused and/or neglected as children then the likelihood of the parent treating their own children the same way is significantly increased (Kagan, 2004).

The bonding cycle is a continual process of building attachments between a parent and child and is reciprocal in nature. Rather than viewing the cycle as something that someone does towards someone else, parents and children reciprocate feelings (or lack of feelings) that can either foster or reject the building of strong attachments. Parents and/or caregivers therefore play a critical role in this 'dance', for if they fall out of step and are not attuned with their infants and children they will not be able to respond to them in the most effective way. Without a secure base from which to grow and explore, infants will not fully experience their environments nor have the trust to explore and deepen their relationships with others. Research also suggests that infant/child characteristics also play a role in influencing the parents' responses to them.

Parents provide the stable support and role-modeling behaviors that introduce infants to what a trusting relationship is all about. Parental risk factors such as poverty, ignorance and lack of emotional availability deprive children of the rich experiences they

require in order to develop secure attachments with others. Infants and children rely on parental love and attentiveness to assure a strong ability to attach and form meaningful relationships. While the absence of the fundamental needs of children does not necessarily guarantee that attachment disorders will develop, the level of attachment and social development will not be as strong as those children who experience love, consistency, and predictability throughout their upbringing.

2. *How does childhood trauma (abuse, neglect, violence, separation) influence the ability to form meaningful attachments with others?*

Trauma early in children's lives sets the standard for viewing the world as unsafe, unpredictable, and untrusting. Accordingly, because of the strong distrust towards the world around them, children will have difficulty forming close, trusting relationships with other people. Cognitively, children living in the shadow of chaos and trauma negatively mold their views of themselves, others, and the world to fit a schema that supports an untrusting, loving, and fearful environment. Unfortunately, children often experience trauma from those that are supposed to provide the most love and protection.. Abuse, neglect, violence, and separation rob children of the fundamental needs of nurturance, predictability, and consistency necessary for overall healthy development.

Trauma significantly influences attachment development due to the influence on all the critical areas of development. Attachment should not be viewed as a single entity in child development because it is shown that various developmental factors converge to create either optimal attachment development or an environment that doesn't allow for successful attachment formation. The frequency of childhood abuse and neglect is increasing, therefore increasing the number of children who grow up in environments

void of love, safety, and consistency. Childhood becomes a time of fear and unpredictability due to the uncontrollable circumstances in their lives.

3. How do attachment disorders manifest in infants and children?

Children with attachment disorders function at levels far below children who have grown up in environments that foster healthy attachment development. Children with attachment disorders display symptoms in many different area of development, causing the disorder to be baffling and difficult to accurately determine. Severe conduct problems may make it easy for professionals to make a diagnosis of oppositional defiant disorder or conduct disorder. It is important to note, however, that the overt behavioral symptoms displayed by a child with attachment difficulties may in fact be the result of unresolved traumas and years of cognitive structuring that causes a child to act the way that they do. Underlying purposes to the conduct problems may identify deeper levels of cognitive and emotional development that have been negatively influenced by trauma and pathogenic care early in life. Negative internal working models appear to be difficult to restructure due to repeated traumas that continually validate and solidify the idea that the world is unsafe and others cannot be trusted.

Children who experience repeated trauma and pathogenic care are unable to properly identify and regulate their emotions, oftentimes resulting in the inability to effectively express themselves. Children model their caregivers approaches to handling situations and expressing emotions in productive ways. If a positive role model is not available, children are left with a whirlwind of thoughts and feelings with no real understanding of what do to with them. Misunderstanding their own thoughts and feelings makes it very likely that these children will not be able to understand others nor learn to develop

empathy. Again, the core of most of the overt conduct problems are strong, unmanageable emotions brought on by years of abuse, neglect, and other significant traumas, as well as the cognitive structuring that supports the negative view of others and the world.

4. *Can children with attachment disorder be healed?*

Many researchers have supported the idea that healthy or unhealthy attachment patterns are not permanent; they can be influenced by experiences that disrupt children's developing perception of themselves and the world. Most research supports the fact that attachment disorders can in fact be "healed" although the process is slow, gradual, and may require years of hard work (Perry, 2000a). Lack of immediate results in attachment-trauma therapy approaches is to be expected due to the amount of emotional work required of the child; patience and dedication to therapeutic growth and change are necessary during the intensive process of healing. Years of negative experiences have continued to validate and support children's internal working model of how they view themselves and others and the reframing of this cognitive structure proves to be a challenging, yet possible, task.

5. *What are some treatment options for children with Reactive Attachment Disorder?*

Children from traumatic and chaotic backgrounds that develop attachment disorders can be treated in a variety of different ways. The child's propensity towards certain treatment approaches can be considered with deciding on a treatment approach. Several approaches work directly with the trauma itself as to help children process the traumatic events in a way to be able to effectively move on in a positive direction. Eye movement

desensitization and reprocessing (EMDR) addresses the traumatic experiences, as does narrative therapy. In narrative therapy, children have the opportunity to 're-write' their personal histories as a way to both acknowledge and then redevelop a past that isn't as harmful or traumatic. Several others therapies work directly with the child and caregiver, such as dyadic developmental therapy or theraplay. In both cases, the positive growth of the parent-child union in safe, nurturing environments slowly allows children to rebuild trust that either faded away or never existed. Connecting cognitions to feelings and behaviors makes CBT interventions important in that it creates a stronger awareness within children how various aspects of their thoughts, feelings, and actions significantly affect one another.

6. *What are some implications for parents, caregivers and professionals in regards to recommending effective treatment interventions and more research?*

According to Bowlby (1988), attachment was once regarded as "infantile" or "regressive" and connected only to early infant and child experiences. He argues, however, that attachment should be viewed as a continual process throughout the entire lifecycle because it is a natural part of the human condition to seek out close relationships and security during times of extreme anxiety and stress. Understanding that the human need for secure attachment is a critical component to healthy development at all stages of life can encourage caregivers and professionals to help promote this in the child's life. Kagan (2004) advises that most of the therapeutic work will be done outside of the therapist's office, implying that caregivers must be up to the challenge of consistently working with traumatized children with attachment difficulties. The more secure, stable,

and consistent the base from which children start from, the more successful children will be throughout all stages of life.

It is important for professionals to be able to recognize the potential for differential diagnoses when considering RAD. Diagnosing children with full-blown RAD is surprisingly rare. Treatment approaches that target the root of the problems, as well as address the severity of the presenting issues, will be effective in working with children with attachment difficulties. Parents and caregivers can come to expect that their involvement in the treatment process will be important to the success of the children's ability to build, or rebuild, attachments with them. The attachment process is reciprocal and both parents and children should expect to be actively involved in order to eventually build sustaining, meaningful relationships. Commitment and motivation to work hard and to be able to overcome setbacks are important qualities, as the treatment process can be exhausting and time-consuming.

Most treatment literature speaks to interventions for children and families already afflicted with attachment difficulties. Wilson (2001) suggested that research efforts should be focused on risk factors and preventative measures that can be taken to decrease the chances of attachment disorders developing in children from traumatic and chaotic pasts. Children who come from chaotic and traumatic backgrounds do not necessarily come to develop attachment disorders. Childhood resiliency is an area of research from which to pull valuable information regarding characteristics and strengths of children who overcome trauma.

Recommendations

The following recommendations are suggested as a result of the review and analysis of existing literature and research:

1. Increase and refine parent/caregiver education and support regarding the predisposing factors and manifestation of attachment disorders, as well as help them to be educated and aware of accurate and effective treatment of attachment disorders in young children.
2. Increase awareness in both professionals and parents of the risk factors and early warning signs identified with attachment disorders and work towards developing preventative models of treatment that decrease the likelihood of attachment disorders to develop and manifest.
3. Focus attachment research on the development of more diagnostic testing for attachment disorders as well as statistical measures to indicate potential risk factors.
4. Encourage professionals to validate and/or challenge empirically-based therapeutic treatment outcomes through continued research.
5. Examine qualities and characteristics of childhood resiliency during traumatic experiences and work to instill those qualities within children and within their environment.
6. Increase understanding of the characteristics of abusing and neglectful parents and learn ways to prevent intergenerational transmission of abuse from parent to child.

There is a large abundance of existing literature and research in the area of attachment and attachment-related disorders. Through the adaptation of early studies by such pioneers as Bowlby and Ainsworth, the field of attachment development is rich in theory and practice. In the spirit of their efforts, it is important to continue making progress in the field of attachment and come to solid understandings of what fosters or hinders attachment as well as what can be done to reestablish attachment. As the literature indicates, the quality of attachment early in life sets the tone for the quality of human development and subsequent relationship formation. It is critical that healthy attachments can be established to ensure a quality of life that is fulfilling and sustaining.

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